PRENATAL CARE: ATTITUDES AND TRENDS OF USAGE AMONG MEXICAN AMERICAN WOMEN

by

Anita Martinez

A thesis submitted to the faculty of
The University of Utah
in partial fulfillment of the requirements for the degree of

Master of Science

College of Nursing

The University of Utah

December 1983

THE UNIVERSITY OF UTAH GRADUATE SCHOOL

SUPERVISORY COMMITTEE APPROVAL

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ABSTRACT

Mexican American women in the state of Utah receive less prenatal care than the general population. This research project consisted of interviews of women from the Hispanic population of the Weber-Morgan District to determine their reasons for not obtaining more prenatal care. The Health Belief Model was used as a conceptual framework to provide direction for data analysis.

A number of interesting results emerged from the data analysis. An inconsistency was noted in that the number of prenatal care visits reported by subjects was greater than the number recorded on Birth Certificates. Most women were satisfied with the amount of care they received. No single factor was implicated in the avoidance of professional prenatal care.

The women expresed a preference for advice from doctors during pregnancy, although physicians were not noted to be consistent sources of information. The women felt that prenatal care should be low-cost and that some care providers should speak Spanish.

The value of supportive programs offered by the local health department was affirmed.

Based on the findings, suggestions were made for the improvement and/or adaptation of prenatal care services which would make them more acceptable to Hispanic women. Suggestions for client education were also made.

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ACKNOWLEDGMENTS

I wish to thank Gail Evans MSN, CNM, Maternal Health Consultant for the Utah Health Department, for bringing my study to the attention of the Weber-Morgan District Health Department, and for her personal support throughout the course of my study.

I am very grateful to Dr. Mark Nichols, Health Officer of the Weber-Morgan District, and to the staff of the Weber-Morgan District Health Department, for all the support and assistance they provided.

I thank John Brockert of the Vital Statistics Division of the Utah Department of Health for his suggestions and advice.

I appreciate the efforts of Miss Bernadette Gomez of the Chicano Student Association of the University of Utah in assisting with the translation of the interview schedule into Spanish.

Finally, I would like to express my profound gratitude and respect to my advisory committee, Dr. Joyce Foster and Dr. Charles Hughes, and most especially to my chairperson, Dr. Joyceen Boyle. They have been patient and supportive. They have

encouraged me to think and explore, and they have helped me reach the end of this study with more interest in the subject than I had at the beginning. They are special people.

CHAPTER I

INTRODUCTION AND REVIEW OF LITERATURE

Perinatal mortality rates are often cited as indicators of the general state of health of a given population. It is a matter of record that among the major nations of the world, the United States has a perinatal mortality rate higher than that of 15 other countries, (Eisner, Hexter, Chabot, Pratt & Sayal, n.d.).

However, if one examines the perinatal mortality records of the United States closely, it becomes evident that there is a great difference in the perinatal mortality rates of various sectors of the population. Traditionally, white or Caucasian perinatal mortality rates tend to be much lower than those of nonwhite groups. Until 1978, the nonwhite classification included such racial groups as Negroes, Orientals, and Native Americans. All groups which were racially designated as Caucasian, despite the enormous variety of ethnic and cultural backgrounds which exists among those groups, were combined in the Caucasian classifi-

cation.

Since 1978, however, a separate category has been added to the classifications used by the Bureau of Vital Statistics: that of "Persons of Hispanic Origin." When the perinatal mortality rates of this group are examined, it becomes apparent that it is not only those groups that are traditionally classified as nonwhite, but also the sector of the Caucasian population which is considered to be of Hispanic origin that contributes to the relatively high perinatal mortality rate of the United States.

For some time now it has been recognized that adequate prenatal care helps to reduce perinatal mortality (DeGeorge, Nesbitt & Aubry, 1971; Ryan, Sweeny & Abiodun, 1980). This is because, while pregnancy is generally considered to be a normal state, it can be associated with numerous disorders which can be dangerous both to the mother and baby. With proper and adequate prenatal care, such disorders (for example, preeclampsia and gestational diabetes) can be detected early and treated in order to prevent or minimize adverse effects. With this fact in mind, in recent years public health agencies at various levels have begun to study the needs and health care practices of local populations, including Hispanic

groups. In those states which record information regarding persons of Hispanic origin in a separate category (e.g., not included with information pertaining to the Caucasian population), a pattern emerges of poor participation in existing prenatal care programs by Hispanic women (Utah Health Systems Agency, 1982). This pattern is characterized by late entry into the health care delivery system when pregnant and fewer prenatal care visits (Mason & Brockert, 1981; Mason, Stapley & Brockert, 1982). If prenatal care to Hispanic populations could be improved, it is possible that the trend toward a higher perinatal mortality rate for that group could be slowed or even reversed.

It is generally recognized that numerous factors affect a person's choices and attitudes regarding health care. The Health Belief Model (HBM) grew out of various independent research projects sponsored by the Public Health Service between 1950 and 1960. Such projects were begun when it was noted that many people in the United States fail to participate in health screening and disease prevention programs, even when such services are offered free or at very low cost. It (the HBM) was based on the work of social psychologists. The most notable of these was Lewin,

developer of the General Field Theory (1935), which held that a person's motivation to act in a given manner was based on the subjective value of the outcome of a particular action as well as the subjective estimate of the extent to which a given action might result in any particular outcome (Maiman & Becker, 1974).

The early parameters of the Health Belief Model, as described by Rosenstock (1974), held that for a person to take action to avoid a disease, he must believe that:

> 1. he was personally susceptible to it,
> 2. that the occurrence of the disease would have at least moderate severity on some component of his life, and
> 3. that taking a particular action would in fact be beneficial by reducing his susceptibility to the condition or, if the disease occurred, by reducing its severity, and that it would not entail overcoming important psychological barriers such as cost, convenience, pain, embarrassment. With respect to (...) early detection of a disease, the same factors were deemed necessary, but in addition there was also the requirement that the individual believe he would have the disease even in the absence of symptoms (p. 3).

Numerous later studies by Rosenstock (1966, 1969), Hockbaum (1956, 1958), Kirscht (1976, 1977), Leventhal (1970, 1971, 1973), Becker (1977), Becker, Drachman, and Kirscht (1972a, 1972b, 1974), Becker, Maiman,

Kirscht, Haefner, and Drachman (1977), and Becker, Nathanson, Drachman, and Kirscht (1977) have tended to support, in various extents, the variables of the HBM. Rosenstock (1974), in describing the evolution of the Model, notes that research using the HBM is far from being complete, definitive, or unified. This is largely attributable to the great number of differing tools and research methods being employed, as well as to the frequently unquantifiable nominal-level data such studies tend to generate.

Nonetheless, certain positive considerations have emerged. For example, modification of health beliefs and subsequent health-related behaviors have been found to be possible (Rosenstock, 1974). However, Rosenstock further notes that it is more difficult to change people than to alter environments. Rather, he suggests it might be more beneficial to enhance public response to offered health services by minimizing or eliminating barriers, arranging environmental stimuli to action, and manipulating social pressures.

The Health Belief Model recognizes that various factors may affect the way in which a person perceives susceptibility to or severity of a given condition. Among those, social factors and cultural influences

are noted (Marston, 1978).

As noted above, pregnancy is a condition which can have potentially serious complications. Prenatal care has been associated with reduced perinatal morbidity and mortality (Ryan et al., 1980; DeGeorge et al., 1971), yet statistics from recent years indicate that some groups of women, including those of Hispanic origin, do not seek or receive such care (Mason & Brockert, 1981; Mason et al., 1982; Utah Health Systems Agency, 1982). Is this true because these women do not perceive pregnancy to be a potentially serious condition? Or is it possible that they do not feel that prenatal health care by a medical practitioner is beneficial? Do some women feel that their actions during pregnancy have little effect on the outcome of the pregnancy? What are the factors which affect these beliefs? Are they mainly cultural or are they socioeconomic in nature?

These questions were among those raised by the Weber-Morgan District Health Department of Ogden, Utah, when the trend toward inadequate prenatal care for some groups within its jurisdiction was noted. The Weber-Morgan District Health Department (WMDHD) planned to establish a prenatal care service at the Health Department Agency in order to meet the needs

of women in the Ogden area. In an effort to determine more accurately exactly what those needs were and what means might be most effective in meeting them, the WMDHD contracted with this researcher to conduct a study among the Hispanic population in the geographic area which was served.

Purpose of the Study

It was the purpose of this study to examine the reasons for which Hispanic women who are documented to have received little or no prenatal health care during a recent pregnancy did not seek more such care. The study examined perceptions of pregnancy and the value of prenatal care, childbearing health locus of control, and various socioeconomic and demographic characteristics of the subjects. Only women of Hispanic origin were included in the study. This allowed the collection of information about a single cultural group which can later be compared with data from other groups.

Research Questions

Very little research has been done in this particular subject area, and it was felt that a way of approaching this investigation was to explore selected research questions. The questions that were investi-

gated were as follows:

1. Why do women of Hispanic origin who fail to get adequate prenatal health care not seek more?

2. Where do women who get inadequate professional health care turn for help and advice during pregnancy?

3. What changes could be made so that prenatal care delivery services would be more appealing to Hispanic women?

The answers to these questions may help provide information regarding factors which affect a woman's pregnancy health care decisions, what could be done to educate these women about the potentially serious nature of pregnancy, and further, to motivate them to seek more prenatal care.

Such information would be beneficial not only to the WMDHD, but would add to the body of nursing knowledge as well. For all nurses, a clearer understanding of the effects of various factors on clients' health care decisions would enable more effective care and improve nurse-client relationships. Nurse specialists, especially those who deal with pregnancy and childbirth, would be able to use the information generated by this study to adapt their services to the needs of the Hispanics under their care. Client education regarding appropriate health care during

pregnancy and encouragement of individual clients' participation in their own care could be encouraged by Certified Nurse-Midwives and Women's Health Care Practitioners.

Review of the Literature

Much has been written about Hispanics in this country. From studies of the demographics of Hispanic people in the United States, Saunders (1954) differentiates the population into three categories. Spanish Americans are those who have lived within the boundaries of what is now the United States since the days of the conquistadores. People who (or whose ancestors) migrated to this country from Mexico around the turn of the century seeking employment are labeled Mexican Americans. Because they have been here for some time, the Spanish Americans and the Mexican Americans tend to be more familiar and comfortable with the English language and with Anglo ways. The third group is composed of more recent immigrants to the United States, including undocumented aliens and seasonal laborers on temporary work permits. These people are usually unfamiliar with the language and customs of this country. Furthermore, they tend to live together and avoid contact with Anglo society thus perpetuating their separateness.

A fourth and varied group not mentioned by Saunders includes immigrants from Spanish-speaking countries other than Mexico and Spain, including Cuba and other Latin American nations. Most of the Hispanics in the Western United States, however, do claim Mexico as their country of origin (Anthony-Tkach, 1981).

Because Mexican Americans comprise the largest group (83 percent) of the Hispanics in the United States (Aday, Chiu & Anderson, 1980), most of the available literature deals with their customs and beliefs rather than those of other Hispanic groups. Numerous anthropological works, including the aforementioned book by Saunders, Cultural Difference and Medical Care (1954), Health in the Mexican-American Culture by Clark (1959), and The Mexican Americans of South Texas by Madsen (1964), describe in great detail the health-related folk beliefs of the Mexican Americans. The extent to which traditional folk beliefs actually determine health-related behaviors depends on many factors which will be discussed later. Because some of these beliefs might affect the childbearing decisions and health care practices of pregnant women, those traditions or folk beliefs pertaining to pregnancy deserve examination.

Traditional Pregnancy-Related Folk Beliefs of the Mexican Americans

Traditionally, children are perceived to be important by Hispanic couples and are desired soon after marriage. If a woman is unable to conceive, she may offer prayers or make use of herbal remedies to enhance fertility. Once she becomes pregnant, she receives instructions from a female relative, usually her mother or mother-in-law, about how to care for herself and the developing baby (Kay, 1978).

Temperature extremes are to be avoided during pregnancy, as are cool drafts and night air. Moonlight, especially during an eclipse, is considered to be capable of causing birth defects, and is often protected against by the wearing of a steel object (scissors or keys) over the abdomen if the woman must be outside at night. Bathing, exercise, and a generally nutritious diet are encouraged. Occasionally, foods may be avoided in order to keep the baby from growing too large. Milk is one of those foods. Cravings are traditionally satisfied so that the baby will not be marked by the food desired. Reaching high or sitting with the legs crossed is felt to cause knots in the umbilical cord and is avoided when possible (Kay, 1978).

Several home remedies have traditionally been

used to relieve the common discomforts of pregnancy. Chamomile tea is thought to relieve nausea and vomiting, as well as aid labor and insure proper separation of the placenta. Flour in water or lemon juice is also used to treat nausea and vomiting. Heartburn may be treated with baking soda. Laxatives and purges may be made from wormwood, bluing, rose petals or pomegranate shell. Self-medication with commercially available preparations is common. Vitamins and iron are believed to be important and may be preferred to folk remedies.

Finally, the emotional state of the women during pregnancy is felt to have definite effects on the baby. Anger is believed to result in miscarriage or premature labor or even difficulties with lactation. Fear may have similar consequences. The thinking of peaceful thoughts is encouraged (Kay, 1978).

The traditional practices just described exist to some extent (depending on various factors, including location, urbanization, and isolation from Anglo communities) in Mexican American communities in this country. Some women who have lived in the United States for many years and have had contact with the Anglo culture may not adhere to any of the folk traditions. Women who have recently arrived or who

have avoided contact outside the home due to language difficulties may retain more of the old beliefs.

Most of the traditional beliefs and practices just noted might have little or no affect on a woman's decision about whether or not to seek prenatal care. Other characteristics of the Mexican American woman have been implicated in the avoidance of health care during pregnancy. Kay (1978) noted that the belief that a baby's survival depends upon the will of God results in a minimum of criticism by family members regarding a woman's decision to seek or not to seek prenatal care.

Barriers to Professional Health Care

There are various reasons why Mexican American women might desire to avoid professional medical care during pregnancy. Cost is always a factor, and in many areas of the country the majority of Mexican Americans belong to the poorer socioeconomic classes (Kay, 1978). Furthermore, Mexican American women are extremely modest, resisting examinations by male health care providers (Abril, 1977; Poma, 1979).

Another barrier to conventional health care is the language difference. As noted above, while women who remain isolated in the home often speak only Spanish, Mexican American children who attend Anglo

schools are encouraged to learn English. These bilingual children are often called from their classes to serve as interpreters when their mothers must visit the doctor (Anthony-Tkach, 1981).

Finally, in the traditional Anglo health care system, patient promptness is insisted upon, even though this may mean that clients are kept waiting for several hours to be seen by the care provider. Hispanics may prefer to skip appointments or may tend to arrive late rather than wait (Spector, 1979).

Parteras

Another aspect of the traditional Mexican American system of health care, which might affect the decisions of a pregnant woman, is the existence of a nonprofessional, folk health care provider, called a partera, or midwife. According to Trotter and Chavira (1981), in some areas of the country parteras may deliver as many as one in five babies. The partera may make use of various herb teas in her practice, but generally relies less on magic than other types of Mexican American folk healers.

To the Mexican American woman, several benefits of receiving care from a partera might be apparent. First, the cost of such care is lower than that of care provided by established, professional personnel

or agencies. Second, parteras are women and often relatives or friends, which allows some preservation of modesty and engenders a sense of trust. Finally, the partera shares the same language, vocabulary, values, and socio-cultural-economic background as the women who seek her care. Use of a partera for home deliveries is seen as a culturally appropriate alternative to hospital care in some Hispanic populations (Trotter & Chavira, 1981).

Cultural

In the preceding sections it has been assumed that selected beliefs and the general lifestyle of Mexican American women may be different from that of their Anglo counterparts. Culture may be the major basis for such differences. Culture has been described as "what individuals say they do, what they want to do, and...what they actually do" in the search for representative ideological patterns (Aamodt, 1978, p. 5). A different way of stating the meaning of culture, expressed by the same author is that it is "all those things which are not inherited biologically...what it takes to be human" (Aamodt, quoted in Howells, 1975, p. 27).

In the two preceding definitions of culture, it is apparent that culture is a very pervasive force in the lives of all people. While people often remain

all of their lives within an area in which their cultural patterns are predominant, there is an increasing likelihood that whole families might move to locations in which the cultural milieu is very different from that to which they are accustomed. As contact with diverse cultural groups occurs and becomes prolonged, changes take place in members of both cultures. Changes which result from such first-hand contact are referred to as acculturation (Aamodt, 1978). Due to acculturation levels, Hispanic women living in the United States may exhibit varying degrees of compliance with the conventional health care system of this country.

Rationale for Hispanic Women's Needs for Prenatal Care

Whether or not it is culture or some other factor (or, indeed, a combination of several factors) that is the reason for the utilization or avoidance of the health care system of the United States by the Mexican Americans remains to be investigated. However, there are in fact differences between Anglo and Mexican American women's patterns of prenatal health care practices. The March of Dimes Birth Defects Foundation Maternal/Newborn Advocate (September, 1982) has noted that Hispanic women not only tend to begin receiving

prenatal care later in their pregnancies than Caucasian women, but they also make fewer visits for such care. This is supported by data from the Utah State Health Department Division of Vital Statistics (Mason & Brockert, 1981; Mason et al., 1982) as well as the National Center for Health Statistics (Ventura, 1982).

Despite the fact that Hispanic women tend to get less prenatal care than Anglo women, it has also been noted in some areas of the country that the neonatal mortality rate among Hispanic infants seems to be relatively low. Several reasons are suggested for this apparent inconsistency. These include differences in recording ethnic background on Birth and Death Certificates, failure to report deaths, and the large numbers of women who come to this country to give birth to their babies and then return to their native Mexico (Powell-Griner & Streck, 1982). The high mobility rate of many Hispanics is also implicated (Trevino, 1981; Power-Griner & Streck, 1982). If this information is correct, the actual Hispanic neonatal mortality rate in Utah might be higher than is currently documented.

Risk factors of pregnancy include age (both extremes), parity, and low socioeconomic status. As noted by O'Brien and Smith (1981), women of high

parity and low socioeconomic class as well as young primigravid women are least likely to seek prenatal care before the second trimester of pregnancy and are most likely to miss one or more prenatal visits. According to the Utah Vital Statistics Reports (Mason & Brockert, 1981; Mason et al., 1982), many Mexican American women giving birth in Utah would fall into one or the other of these high-risk categories.

The dominant Anglo culture of the United States accepts the belief that prenatal care is important and that a certain amount of such care does contribute to optimum maternal and neonatal outcome (Ryan et al., 1979). It is therefore not surprising that in recent years, public health agencies have become concerned with seeking out populations who are not receiving the necessary care and are searching for means of attracting them into the accepted health care system. This task might prove difficult. If it is the cultural characteristicss of the Mexican Americans which influence their health-related behaviors, then either a way must be found to acculturate the Hispanics to the use of the existing system, or the system must be adapted to the Mexican Americans, possibly at the expense of its attraction to Anglos.

As implied in the description of traditional

folk beliefs concerning pregnancy, Mexican Americans may tend to have a poor understanding of the physiology, and potential for complications, of pregnancy. According to Social Learning Theory as postulated by Bandura (1971), motivation to try to prevent such consequences by seeking prenatal care might require a basic understanding of the physiological processes of pregnancy. Furthermore, a realization of the possible consequences of various actions (or failures to act) may contribute to motivation. Bandura stated: "By representing forseeable outcomes symbolically, people can convert future consequences into current motivations of behavior" (p. 18). If Hispanic women were to understand the potential for serious problems associated with pregnancy and the value of prenatal care in minimizing the risk of those problems, they might, following the reasoning of Bandura, be more motivated to seek effective prenatal care in order to avoid complications which might endanger themselves or their babies.

Locus of Control

A concept which is important to the idea of motivation to act in a certain way is that of locus of control. An external locus of control indicates that life situations are perceived by the individual to be subject less to the results of one's own actions

and decisions than to fate or to the whim of powerful others. If an individual believes, however, that his/her actions can potentially change the outcome of a given event, he/she is said to have an internal locus of control. Phares (1976) notes that Hispanics tend to exhibit a more external locus of control than do Anglos. A deep-seated belief that one's own actions are of little consequence to future outcomes might inhibit motivation, or at least alter an individual's response to a given situation.

An internal locus of control might not, however, indicate a greater willingness to assume a different pattern of behavior. As suggested by Rotter (1966), a person may have a very strong internal locus of control but may fail to take a given action (for example, the seeking of prenatal care) for a number of other reasons such as ignorance, fear, or dislike of the health care system. Furthermore, the individual may be taking certain actions in accordance with a belief on his/her part that it is the action which is being taken that will have the most desired effect on future outcomes. Thus, women who ascribe to many of the very old folk beliefs of the Mexican American health care tradition may feel that the rituals that they practice are of more benefit to themselves and

their babies than anything that the modern health care system has to offer.

Summary

In summary, it has been documented in recent years that Hispanic women get less prenatal care than do Anglo women. This may be due to several factors, including cultural differences and/or socioeconomic status. A decrease in perinatal mortality has been shown to be associated with adequate prenatal care. Because of this, public health offices in many areas have begun to study the problem, seeking ways of both improving the quality of prenatal care available to Mexican American women and of encouraging those women to take advantage of the care that is offered. This study was designed to help explore both current health care practices of Hispanic women and those qualities that they desire from a health care delivery service, in an effort to assist the Health Department in the Weber-Morgan District to provide effective prenatal care to all women within its sphere of influence.

Current information regarding the attitudes and behaviors of pregnant Hispanic women will be of benefit to nurses and especially Certified Nurse-Midwives who provide prenatal care to those women.

CHAPTER II

METHODOLOGY

Definition of Terms

Prenatal care is defined as visits to a licensed doctor or Certified Nurse-Midwife during pregnancy for the purpose of monitoring fetal and maternal health and for the provision of pharmacologic, medical and educational support necessary to maintain fetus and mother in optimal health throughout gestation. For the purposes of this study, inadequate prenatal care was considered to be anything fewer than seven visits during a single pregnancy.

Women of Hispanic origin were selected on the basis of being so identified on their babies' Birth Certificates, if such information was available. When Birth Certificates were not used for subject selection, only women who would have been identified as being of Hispanic origin on a Utah Birth Certificate had one been available were interviewed. It is recognized that these women represent varying levels of acculturation.

Procedures

This research project is a descriptive study which was conducted in accordance with the terms of a contract between the Weber-Morgan District Health Department and the researcher. It consisted of a structured interview using an interview schedule developed by the researcher for the purposes of the study. Data were collected from December 1982 through March 1983 during interviews conducted in the homes of consenting subjects. Analysis of the data collected included computer processing of codable data and a description of various responses which could not be coded. The results of the data analysis have been provided to the Weber-Morgan District Health Department to be used in the development of a prenatal care service. Followup research among other groups of women utilizing the interview schedule is also anticipated.

The original population from which a sample was to be selected consisted of those women residing in the Weber-Morgan District who were of Hispanic origin (as listed on 119 Birth Certificates of infants born during 1981 and 1982) who had fewer than seven visits for prenatal care during the pregnancy represented by the Birth Certificate used for selection. This

group comprised the entire population of Hispanic Weber-Morgan residents who received inadequate prenatal care during the years 1981 and 1982, but was a subset of the area's Hispanic population as a whole. A sample of 80 women was considered to be sufficient for validation of the tool. A sample of 40 was felt to be adequate for data analysis and description.

Because research involving the use of information on Birth Certificates must be approved by the Utah State Health Department, the interview schedule and a brief research proposal were submitted to the Director of the Statistics Division of the State Health Department for review. After approval was granted and a research agreement signed, a computer-generated list naming qualified subjects and including information available on Birth Certificates was provided. Copies of qualifying Birth Certificates were also made available by the Weber-Morgan Health Department.

The personal interview was determined to be the mode of data collection which would result in the highest participation rate. One reason for this is that it was believed that a relatively high proportion of women in the population might be at least partially illiterate and might therefore have difficulty completing a questionnaire if it were sent to them

by mail. A visit to the subjects' homes further allowed the researcher to determine the appropriate language in which to present the questions. The cost of mailing two 14-page questionnaires (one in English and one in Spanish) as well as instructions in both languages for completing and returning them would have been prohibitive. Finally, it has been documented that the face-to-face interview should result in a lower refusal rate than other data collection methods (Polit & Hungler, 1978).

Approximately one week prior to the proposed interview, each of the 119 women in the population represented by the Birth Certificates was notified by mail in a short note written in both English and Spanish describing the purpose of the intended visit (the majority of these notes were returned because the addressee had moved and left no forwarding address). The telephone number of the Weber-Morgan Health Department was provided in the note should the women have any questions regarding the study. Each home was visited at least once and, if no one was home, revisited on another day at a different time.

When a subject was contacted at her home, the researcher introduced herself as a nurse working with the Health Department and stated the purpose of the

visit. In this initial contact it was determined which language (English or Spanish) was most comfortable for the subject, and that language was spoken for the remainder of the interview. At this time the subject was informed of her right to refuse to participate in the study, or to withdraw at any time, and any questions she may have had at the time were answered. If she refused to participate (only one qualifying woman contacted during the door-to-door search did so), she was placed under no pressure to cooperate, and the contact was ended at that point. If the subject agreed to grant an interview, she was asked to sign a consent form written in the appropriate language. The signed copy of the form was kept by the researcher, and another copy was given to the subject. The consent form also listed the telephone number at the Health Department where the researcher could be contacted.

The structured interview, which took approximately one hour, was based on a tool developed by the researcher. The questions were read to the subject in either English or Spanish by the interviewer (also referred to as the researcher). A list of potential responses was also read to the subject and her choice coded on an optical scan sheet. Answers which required

explanation or which were not found in the lists of possible responses (an "Other" option was included when applicable to allow for subjective elaboration and in an attempt to minimize the extent to which the tool defined subject responses) were recorded on a separate worksheet.

In the time allotted for data collection, 20 interviews were obtained according to the original selection criteria. This group of interviews will be referred to throughout the remainder of this study as the Birth Certificate subsample.

By mid-January 1983, it had become evident that the originally planned method of subject selection would result in an insufficient number of interviews for analysis. While no subject who was located at the address shown on a Birth Certificate refused to grant an interview, the number of women in the overall population of Hispanic women with fewer than seven prenatal care visits who had moved and could not be located made it impossible to obtain even a total of 40 interviews using Birth Certificate information as selection criteria.

Because the Utah State Vital Statistics Reports of 1979 (Mason & Brockert, 1981) and 1980 (Mason et al., 1982) suggested that Hispanic women as a group tended

to receive less prenatal care than women of other ethnic categories it was decided to eliminate some of the restrictions of the criteria for sample selection. Since the Hispanic population was apparently highly mobile, it was decided that use of Birth Certificate information was an inefficient means of sample selection. A convenience sample, to be obtained through a door-to-door search and through subject referrals, was determined to be the most practical means of collecting sufficient data for analysis.

The subject selection criteria were restated as follows: to qualify for participation in the study a woman must be of Hispanic origin, reside within the Weber-Morgan District, and have given birth to a viable infant within the last five years. The door-to-door search was conducted in areas with large Hispanic populations. In cases of referrals by other subjects, the person who provided a name and address or phone number remained anonymous. By the end of the data collection period, 20 additional interviews had been obtained using the revised criteria for subject selection. This group of interviews will be referred to throughout the remainder of the study as the Convenience Subsample.

All together, a total of 40 interviews was

obtained. For the majority of data analysis the two subsamples (20 interviews in the Birth Certificate Subsample and 20 interviews in the Convenience Subsample) were combined and treated as a single group to be referred to hereafter as the Interview Sample.

Instrument

The interview schedule was developed especially for this study. It was originally written in English and was translated into Spanish with the help of Ms. Bernadette Gomez of the Chicano Student Association of the University of Utah.

The interview schedule consisted of eight sections. Several of the questions were taken directly, or adapted from, a tool used in the California community of Florence-Firestone by Lee (1976), and were adapted for the present study with his permission. Section 1 contained questions relating to the subject's beliefs about health care in general and during pregnancy. Section 2 listed possible attributes of an hypothetical prenatal care service, which subjects were asked to rate according to whether they considered each attribute to be very important, important, or not important. In this section subjects were also asked to suggest any other qualities which would be important to them when selecting a prenatal care service. Section 3

was developed by Foster (1981) to test childbearing health locus of control. Sections 4 through 8 dealt with the subject's financial status, past childbearing history, social contacts or isolation, and information-seeking practices.

With a few exceptions, most questions were in multiple choice form. This allowed easy coding of answers for computer analysis. However, not all questions were close - ended. As noted earlier in this discussion, an "Other" option was frequently available in order to allow the subjects to respond when their own experience was not reflected in the answers provided. Furthermore, six open-ended questions, dealing with self-care during pregnancy were presented in the first section. No answer lists were provided for these questions.

The questions, which were reviewed by five health care professionals and three lay people, were believed to be valid with regard to the content presented. None of the items seemed to be consistently confusing to subjects during the interviews, although the locus of control questions occasionally required explanation (the entire concept of control over the childbearing experience seemed to be foreign to some of the women). None of the items provoked inappropriate responses

from any subject.

Reliability and validity of Section 3 (Child-bearing Health Locus of Control) has been demonstrated with several non-Hispanic populations (Foster, 1981). The results obtained in this section during the present study appear to verify its validity among Hispanic women and support its overall reliability as well.

Statistical validity of the entire tool cannot be determined using the results of this study as the interview sample was too small. Reliability cannot be confirmed until the instrument has been used several more times, preferably among diverse populations.

CHAPTER III

RESULTS AND DISCUSSION

Analysis of Data

As discussed in the previous chapter, three groups of data were obtained during the course of this study. First, 119 Birth Certificates, which represented the entire population of Hispanic women in the Weber-Morgan District who failed to receive adequate prenatal care, were available. These Birth Certificates, from the years 1981 and 1982, provided a description of that population. Second, optical scan sheets, which contained responses to all of the close-ended questions asked during the interview, were available for each of the 40 women in the Interview Sample. Finally, for each of those 40 women there was also a worksheet which contained answers to the open-ended questions that were asked, as well as any answers which could not be recorded on the optical scan sheets.

Analysis of the nominal data obtained during this study was performed using Pearson r correlations where applicable. Simple response counts and percen-

tages were calculated for all questions. For items involving ordinal level data (e.g., age, years of education, and number of prenatal visits), ranges, means, and standard deviations were also calculated. Content analysis of all information recorded on the worksheets was performed as well.

Demographic Data

Birth Certificate Population (N=119)

As previously noted, the 119 Birth Certificates available represented the entire population of Hispanic women in Weber and Morgan counties (Utah) who received fewer than seven prenatal checkups during the years 1981 and 1982. This was not the total Hispanic population of the area. Those Hispanic women who had seven or more prenatal visits were not included when Birth Certificates were selected. Any comparisons made between this group and the two subsamples can be generalized only to the population of Hispanic women who failed to receive adequate prenatal care (see Table 1).

Ages of the women ranged from 14 to 42 years, with a mean age of 22.5 years and a standard deviation of 5.5 years. Sixty-four (54%) of the women were married; 55 (46%) were single. Parity, which was

Table 1

Demographic Data: Comparison of Characteristics of the Population of Hispanic and Childbearing Women of Weber and Morgan Counties from Birth Certificate Information with Characteristics of the Interview Sample of Hispanic Women

Variable	Birth Certificates (N = 119)	Interview Sample (N = 40)
Age in years	14-42 mean 22.5	16-42 mean 24.5
Married	64(54%)	26(65%)
Single	55(46%)	14(35%)
Education	2-14 mean 10.1	0-14 mean 10.1
Parity	1-9	1-6
Occupation:		
housewife	91(76%)	30(75%)
clerical	9(7.5%)	4(10%)
high school/ trade school student	8(6.6%)	6 (15%)
service worker	1(1.4%)	
sales	1(0.7%)	

based on the number of children who were born alive and were still living at the time that a Birth Certificate included in the study was completed, ranged from one to nine. Fifty-two (44%) of the women were born in Utah, 55 (46%) were born in another State, and 12 (10%) were born in Mexico.

Education levels ranged from 2 to 14 years, with a mean of 10.1 years and a standard deviation of 2.19 years. The education of the spouse was also included on Birth Certificates. Levels ranged from 2 to 16 years with a mean of 9.7 years (possibly reflecting the need for the men to leave school early to seek employment) and a standard deviation of 3.53 years.

Ninety-one (76%) of the women considered themselves to be housewives. Nine (7.5%) held clerical positions, eight (6.6%) were laborers, eight (6.6%) were high school or trade school students, two (1.3%) worked in service occupations, and one was a saleswoman. The occupations of husbands (when applicable) are also noted on Birth Certificates. Fifty-three (76.8%) of the men were laborers. Seven (10.1%) worked as craftsmen. Four (5.8%) were either high school or trade school students. Two (2.9%) each listed their occupations as service worker or as professional/college

student. One held a clerical position.

Interview Sample (N=40)

Ages of the women who were interviewed ranged from 16 to 42 years, with a mean age of 24.5 years and a standard deviation of 5.38 years. Parity for the Interview Sample was determined based on the number of term and premature births, and ranged from one to six. Twenty-six (65%) of the women were married; 14 (35%) were single. Thirty-four (85%) subjects were United States citizens and six (15%) were not.

The length of time each woman had been in the Weber-Morgan area when her last baby was born was also noted. Six (15%) of the women had been in the District for less than six months, two (5%) had lived there between six months and two years, thirteen (33%) had resided in Weber-Morgan for more than two years but not for their whole lives, and 19 (48%) had lived there since birth.

Interview subjects' education levels ranged from zero to 14 years, with a mean of 10.1 years and a standard deviation of 3.13 years. Education levels of the women's partners were not obtained. Thirty women (75%) listed their occupation as housewife, six (15%) were students in high school, and four (10%) held clerical positions. When possible, occupations

of spouses or partners were also obtained. Eighteen (54%) of the men were laborers. One each was listed as a high school student, service worker, operator, and college student. One also held a clerical job. Ten of the women did not list an occupation for the father of their last baby.

The financial status of the women in the Interview Sample was also investigated. The majority of women interviewed stated that their family's average take-home monthly income ranged from between $200 and $400 (15 or 37.5%) to between $400 and $600 (13 or 32.5%). Three of the women (7.5%) reported an average monthly income of less than $200, and nine (22.5%) stated that their family's income was more than $600 per month.

Twenty-one women (52.5%) were receiving some sort of welfare assistance, usually monthly checks or food stamps, or both. Three women (7.5%) received Social Security benefits, and 17 (42.5%) had assistance from Medicaid for assistance with medical expenses.

Only five of the women interviewed (12%) were employed outside of the home. Fourteen (35%) reported that their husband or boyfriend was working. An additional ten women (25%) stated that their partner was unemployed.

Analysis and Comparison

The Interview Sample was similar to the population represented by the Birth Certificates in most respects. The difference in the mean ages of the groups (the Birth Certificate population had a mean age of 22.5 years and the Interview Sample had a mean age of 24.5 years) was not significant. A higher percentage of women in the Birth Certificate population was unmarried (46% compared with 35% of the women in the Interview Sample).

Parity was determined in different ways for the Birth Certificate population as a whole and for the Interview Sample. The Birth Certificate listed the following: live births now living, live births now dead, terminations at less than 20 weeks, and terminations at more than 20 weeks. The women in the Interview Sample were asked to report the number of term pregnancies, the number of preterm pregnancies, the number of miscarriages and abortions, and the number of children now living (adjustments were made to the interview schedule to allow an interviewer to obtain information which can be compared directly to that which appears on Birth Certificates). The range of parity for the Birth Certificate population (one to nine--computed from the total number of live births,

whether the children are now living or dead) is somewhat larger than that for the Interview Sample (one to six--computed from the total of term and preterm births).

The Birth Certificates listed place of birth of the mother. If women born either in Utah or another state were considered to be United States citizens, and women born in Mexico considered to be Mexican citizens, then approximately 90% of the women in the Birth Certificate population were citizens of the United States and 10% were citizens of Mexico. While it is impossible to determine from Birth Certificate data if a woman received citizenship in the United States, or if, despite birth in another country she was always a United States citizen, these figures are comparable to those of the Interview Sample, of which 88% were United States citizens and 12% were citizens of Mexico.

The mean education levels were the same (10.1 years) for both groups. The predominant occupation of the women in both the Birth Certificate population as a whole and the Interview Sample was "housewife," with 76% of the women in the first group and 75% of the women in the second group (the Interview Sample) stating this to be their occupation. For both groups,

the majority of husbands or partners tended to be employed as laborers, with 54% of those listed by the Interview Sample and nearly 77% of those listed on the Birth Certificates belonging to that job category. The remainder of the men in both groups was spread fairly evenly in relatively small numbers among various other occupations.

Research Question One

Research question one stated:

> Why do women of Hispanic origin who fail to get adequate prenatal care not seek more?

The amount of prenatal care received was one of the original selection criteria. Inadequate prenatal care was determined arbitrarily to be a total of fewer than seven visits for such care during the course of a single pregnancy. Data regarding the amount of prenatal care received was available for the population as a whole that was represented by the 119 Birth Certificates. All of the women in the Interview Sample were asked to describe the prenatal care they received during their last pregnancies. Forty interviews formed the Interview Sample as noted earlier: 20 from the Birth Certificate subsample (or those women whose addresses were obtained from a Birth Certificate) and 20 from the Convenience subsample (or

those women located through the door-to-door search or through referrals).

Responses to questions dealing with prenatal care indicate that most of the Hispanic women in the Interview Sample believe that they received adequate prenatal care. Frequently, the women in the Birth Certificate subsample reported having more prenatal care visits than the number of visits recorded on Birth Certificates. Reasons given by the women for not receiving more prenatal care varied, indicating that no single social or economic factor is responsible for the Hispanic population's decreased use of prenatal care services.

Description of Prenatal Care Received

The number of prenatal visits for the women in the entire Birth Certificate population ranged from zero to six with a mean of 4.42 visits and a standard deviation of 1.5 visits. The month of pregnancy in which prenatal care was first received by the women in the population was also noted on the Birth Certificates. The range was from zero (no prenatal care received) to nine (care received in the final weeks of a term pregnancy) with a mean of 4.06 months and a standard deviation of 2.1 months.

The fact that a reduced number of prenatal care visits was one of the subject selection criteria was not made known to the women in the Birth Certificate subsample. Although the Birth Certificate by which each of these women was located recorded that she had received fewer than seven prenatal care checkups, 15 of the 20 women in the Birth Certificate subsample stated during their interviews that they went to their care providers more than six times for care during their last pregnancy (range 2 to 20 visits). There was no significant correlation found between the number of prenatal care visits recorded on the Birth Certificates and the number stated by the same subjects during their interviews.

There are several possible explanations for this inconsistency. A number of these might result from the way in which information is obtained for the Birth Certificates. If the number of prenatal visits is determined by prenatal records from the woman's care provider, it will be accurate, unless the woman had received care from another provider or those records were unavailable at the time of delivery. The prenatal care of a woman who had recently moved and had not transferred records from her previous care provider might be grossly underestimated if such records were

the only means of determining the amount of care received.

Another problem might arise if the woman (or her partner) were asked how many visits she had for prenatal care. After as many as eight months of receiving care, it would be difficult to remember exactly how many visits were made to the care provider. Furthermore, the excitement of the occasion of the birth of a baby might tend to make a woman or her partner forget the details of the past months. Finally, Aday et al. (1980) note that Hispanics might tend to "overestimate physician contact rates" somewhat more than the general population (p. 373).

For the remaining 20 interviews comprising the Interview Sample (those of the Convenience Subsample), the number of prenatal visits according to public records was not a criterion for selection. Three of the women in this group had six or fewer prenatal care visits during their last pregnancy, and one did not remember how many she had. The remaining 16 women (80%) stated that they had had more than six (overall range 2 to 25) visits. The difference in reported number of visits for prenatal care between the two groups was not statistically significant, despite the difference in selection criteria. Because of

this similarity between the two subsamples, they will not be treated as separate entities for the remainder of this discussion; rather, the Interview Sample, which is composed of the two subsamples just discussed, will be considered as a single group.

Reasons for Limiting Prenatal Care

One question (numbers 209-217 in section VI of the Interview Schedule) specifically asked the subjects what their reasons were for not receiving more prenatal care. Of the 40 women in the Interview Sample, 37 (or 92%) felt that they had received enough prenatal care and so did not need more (as noted earlier, seven of the women actually reported having had six or fewer prenatal care visits). This means that four, (or 10%) of the women, felt that they had received adequate prenatal care despite the fact that they had fewer than seven visits for such care.

Four women felt that prenatal care, as defined in this study, was not important. Three were among the group who had had six or fewer prenatal care visits and who felt that they had received enough prenatal care. The three women who comprised this group were single. Their ages were 21, 22, and 29 years. All three had several living children: two had three

children at the time of the interview, and one woman had four.

Two of the women used the Weber-Morgan District Health Department for health care. Both of these women were enrolled in the WIC (Women-Infants-Children) program at the Health Department and had a fairly good understanding of self-care and nutrition during pregnancy. The third woman was receiving WIC food supplements, but stated that she relied on her own personal experience for most aspects of self-care. Her understanding of this area was limited and she held several of the beliefs traditionally associated with the folk health care system. She used local hospital emergency rooms when she felt that she needed medical attention.

All of the women spoke both English and Spanish, although all three considered English to be their primary language. None of the women had completed high school. Two had finished the tenth grade and one had completed the eleventh grade.

All women ranked in the lower economic divisions of the sample according to their average monthly take-home incomes. One woman had an average monthly income between $200 and $400 for her entire family. The average monthly incomes for the other two was less

than $200. All received monthly welfare checks.

The reasons for these womens' denial of the importance of prenatal care are subject to speculation. In accordance with the Health Belief Model, they must either not consider pregnancy capable of resulting in severe problems or they do not consider themselves susceptible to those problems (possibly because all had experienced previously uncomplicated pregnancies). It is also possible that the barriers which they perceived to prenatal care such as cost, long waits, or embarrassment outweigh the perceived benefits. The WIC program emphasizes health maintenance during pregnancy, so it is unlikely that the women were totally unaware of what is considered to be acceptable prenatal care.

Possible reasons for the avoidance of professional prenatal care were presented to the entire Interview Sample in a list. Nine (22.5%) of the women reported that they did not seek more prenatal care because they did not feel sick. Nine women (22.5%) also listed lack of transportation as a reason for missing visits; while four women (10%) expressed dislike of the required physical examinations by care providers, twice as many (eight or 20%) listed examination by a man as a reason for avoiding the medical system. Four women

(10%) stated that they could not afford more prenatal care. Despite the fact that six of the women were not United States citizens, none of them avoided the professional health care system because they feared their status as a nonresident might be reported to immigration authorities (see Figure 1).

Four women had reasons for missing appointments that were not included on the list. One woman complained that her doctor was very strict about appointment scheduling, but when she arrived, she was often required to wait for long periods of time before being seen. A women who had recently moved into the Ogden area stated that she did not know where to go for prenatal care. Another reported that her medical card had expired during her pregnancy and her doctor had refused to see her until it was renewed. The fourth woman did not state specific reasons for selecting the "other" response to this question.

Several factors seem to influence the subjects' decision to limit their prenatal care. Most of these relate to perceived barriers to the care. Of the two barriers mentioned most often, one (lack of transportation) has an economic base and one (dislike of physical examination by a male care provider) reflects the cultural modesty of the Mexican American

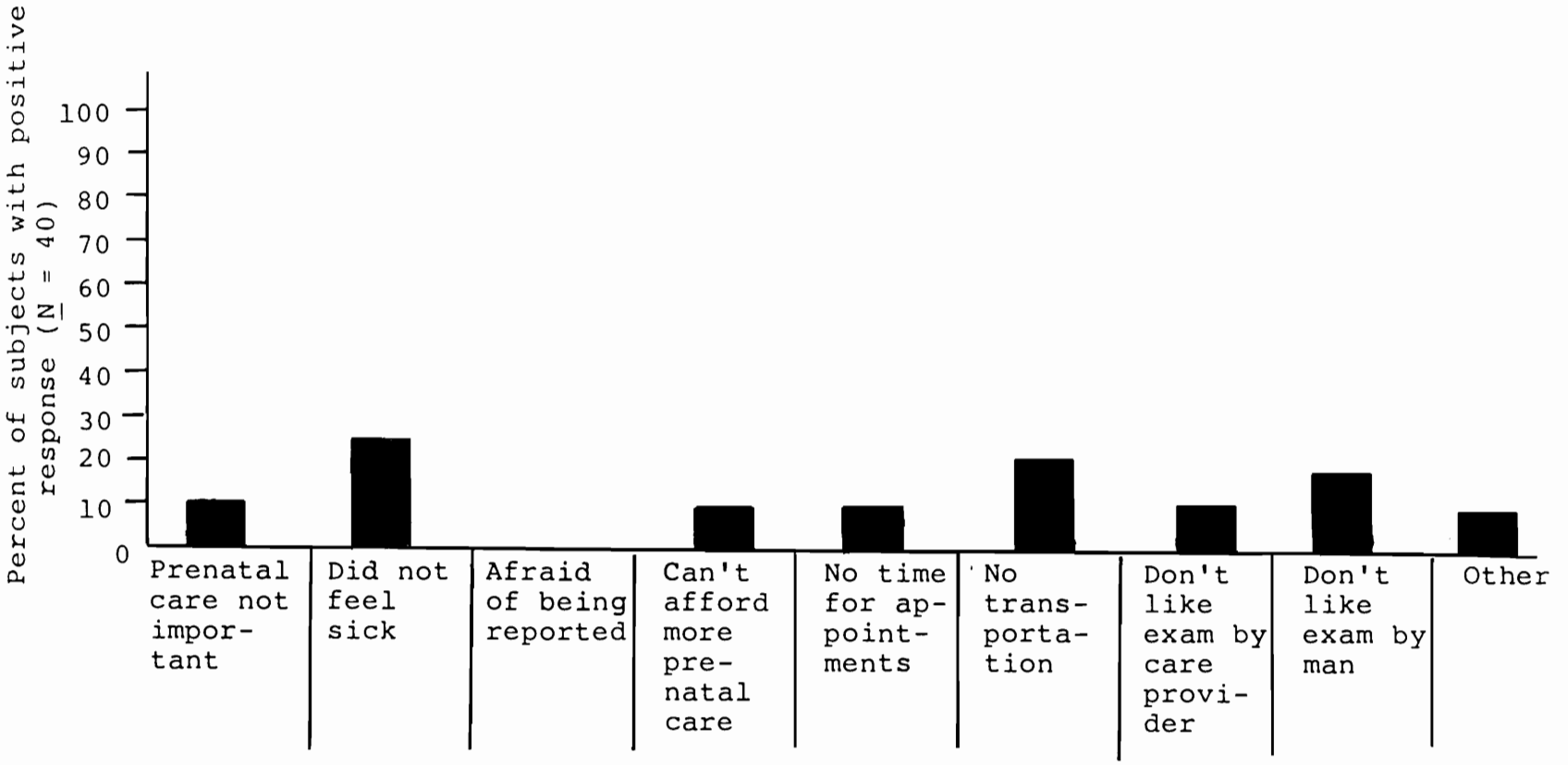

Figure 1. Subjects' reasons for avoiding prenatal care (N = 40).

woman. One other factor relating to the Health Belief Model can be noted from responses to this portion of the interview. As noted earlier, for an individual to take an action related to preventive health care or health screening, she must perceive herself to be susceptible to possibly severe complications in the absence of debilitating symptoms. In this study, 22.5% of the subjects missed appointments because they "did not feel sick."

In general, the findings appear to indicate that Hispanic women are actually receiving more prenatal care than is reflected by current methods of public documentation. This suggests the need for a more accurate and consistent program of obtaining and maintaining public information.

It is also apparent from the results of this investigation that several different factors are related to the prenatal care decisions of the Hispanic women of the Weber-Morgan District. These findings differ from reports of earlier researchers which indicate that either culture (Clark, 1959; Madsen, 1964) or socioeconomic status (Farge, 1978; Lee, 1976) might be the major factor influencing health care decisions. The results of this investigation indicate a need for further research to verify the findings. The

study results emphasize the importance of a broad range of programs, including education and financial assistance, and elimination of the concerns expressed by the women in the interview sample.

Research Question Two

Research question two stated:

> Where do women who get inadequate professional health care turn for help and advice during pregnancy?

Findings to be discussed in this section indicate that in matters relating to pregnancy the Hispanic women who were interviewed prefer to utilize the services of a physician. However, even when a physician was available, he or she did not provide complete or consistent information regarding self-care, nutrition, and medication during pregnancy. The women described social support systems consisting of family and/or friends which provided information and support during pregnancy. Most frequently, the women were likely to rely on their own experience when taking actions relating to pregnancy.

Several questions dealt specifically with the subject of preferred sources of support and information during pregnancy. Question 41, Section 1 asked: "If you get pregnant or have family problems related to your pregnancy, to whom do you go first for advice

and help?" The majority of the subjects (27 or 67.5%) (Figure 2) said that they would go first to their doctor seeking help and advice concerning pregnancy or related problems. Seven (17.5%) said that they would turn first to relatives for help and advice. Five of the women (12.5%) stated that they would approach their mothers first for such support. One woman reported she would talk to her social worker.

When asked who they would talk to if they had questions about pregnancy (subjects were asked to select all those whom they might ask), 25 (62.5%) of the women stated that if they had questions about pregnancy they would ask their doctor. Fourteen women (or 35%) said that they would ask their mothers. Thirteen (32.5%) of the women stated that they would ask a relative questions concerning pregnancy. Five (12.5%) of the women said they would talk to a nurse if they had questions about pregnancy. Friends were information sources for four (10%) of the women. One woman said she would ask her grandmother, and one woman said that she talked to her husband when she had questions regarding pregnancy (Figure 3).

The women were then asked whose advice they preferred to take concerning what they should or should not do when pregnant. Twenty-nine (72.5%) of the

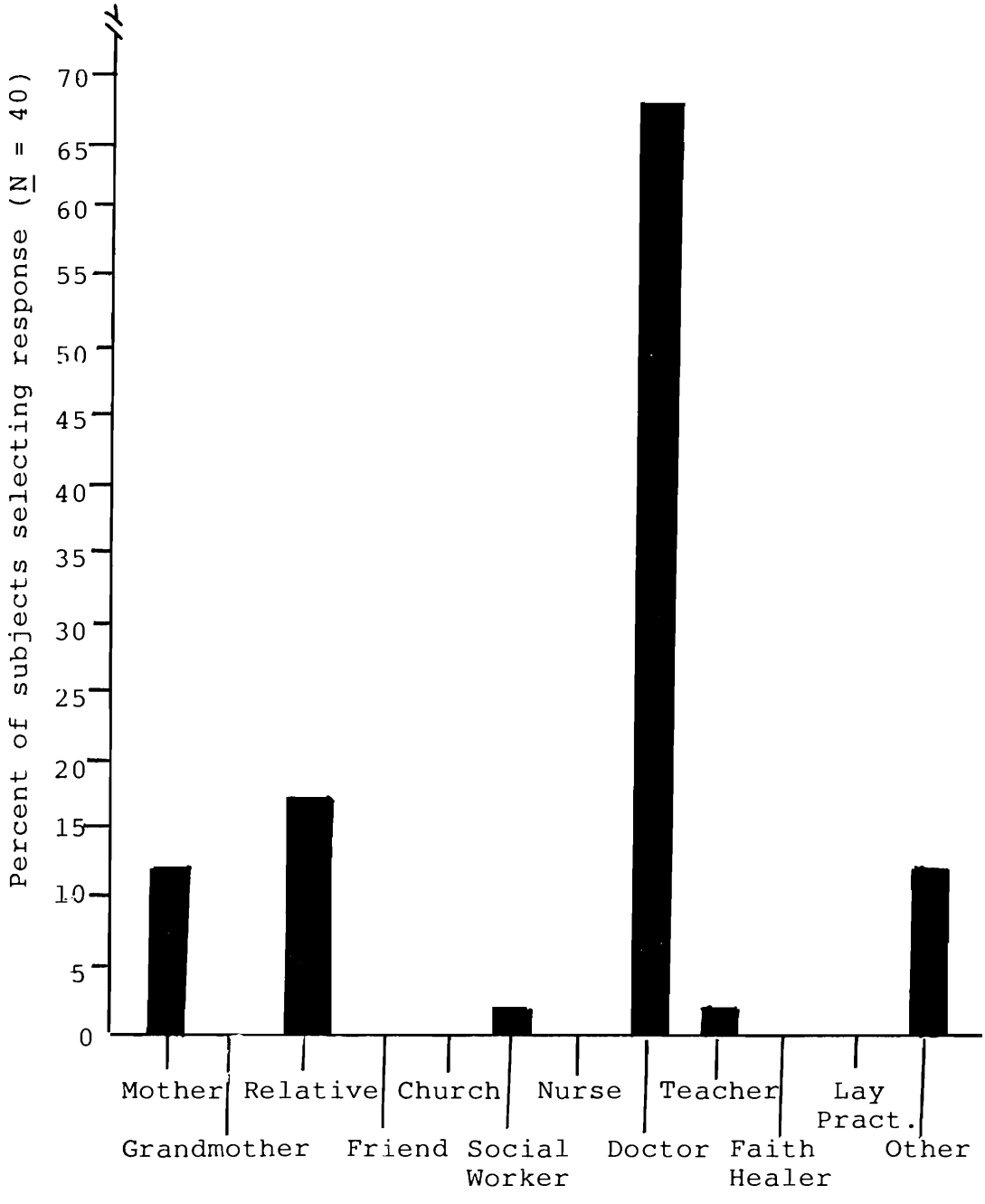

Figure 2. Sources of advice concerning pregnancy and/or problems (N = 40). Subjects could select any that applied.

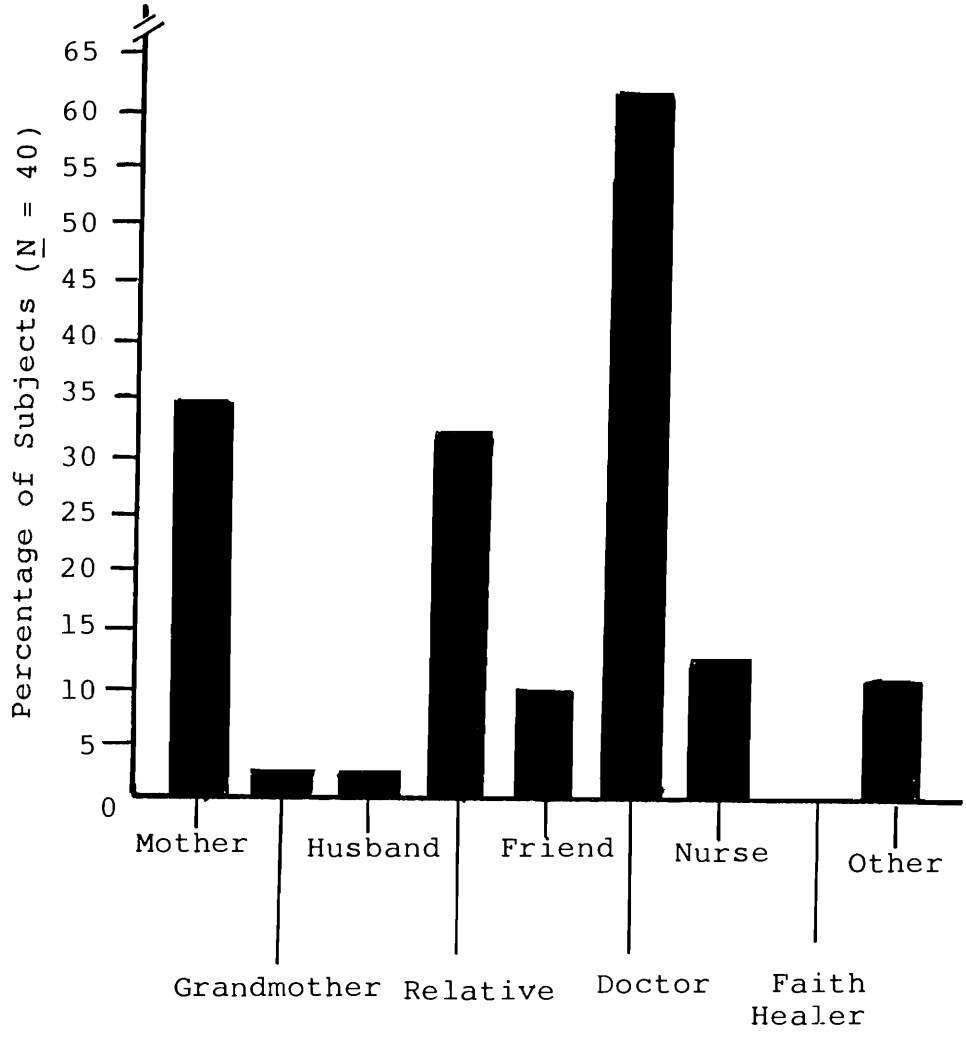

Figure 3. Sources of information regarding pregnancy as reported by sample (N = 40). Subjects could select all that applied.

subjects said that they preferred to seek advice about pregnancy from a doctor. Six (15%) preferred to go to their mothers for such advice. Two women (5%) stated that they would rather take advice from friends about what to do or not do when pregnant. One woman stated that she preferred to take her husband's advice, and one woman stated that she preferred to seek such advice from a nurse (Figure 4).

For all of the questions just discussed, a list of possible replies was presented to the subjects. The list consisted of ten choices, one of which was "Lay practitioner" which included nonprofessional health care providers such as curanderas and parteras. This choice was not selected by any of the subjects, indicating a lack of use of folk health care providers by the women in the Interview Sample. This may be because such individuals are not known to be available in this geographic area.

The women were then asked specific questions concerning health care during pregnancy, and then to describe where they obtained the information. The responses to these questions are summarized in Table 2. It is apparent that though the women might prefer to get information or advice from a doctor, in most cases the doctor was not in fact a consistent source

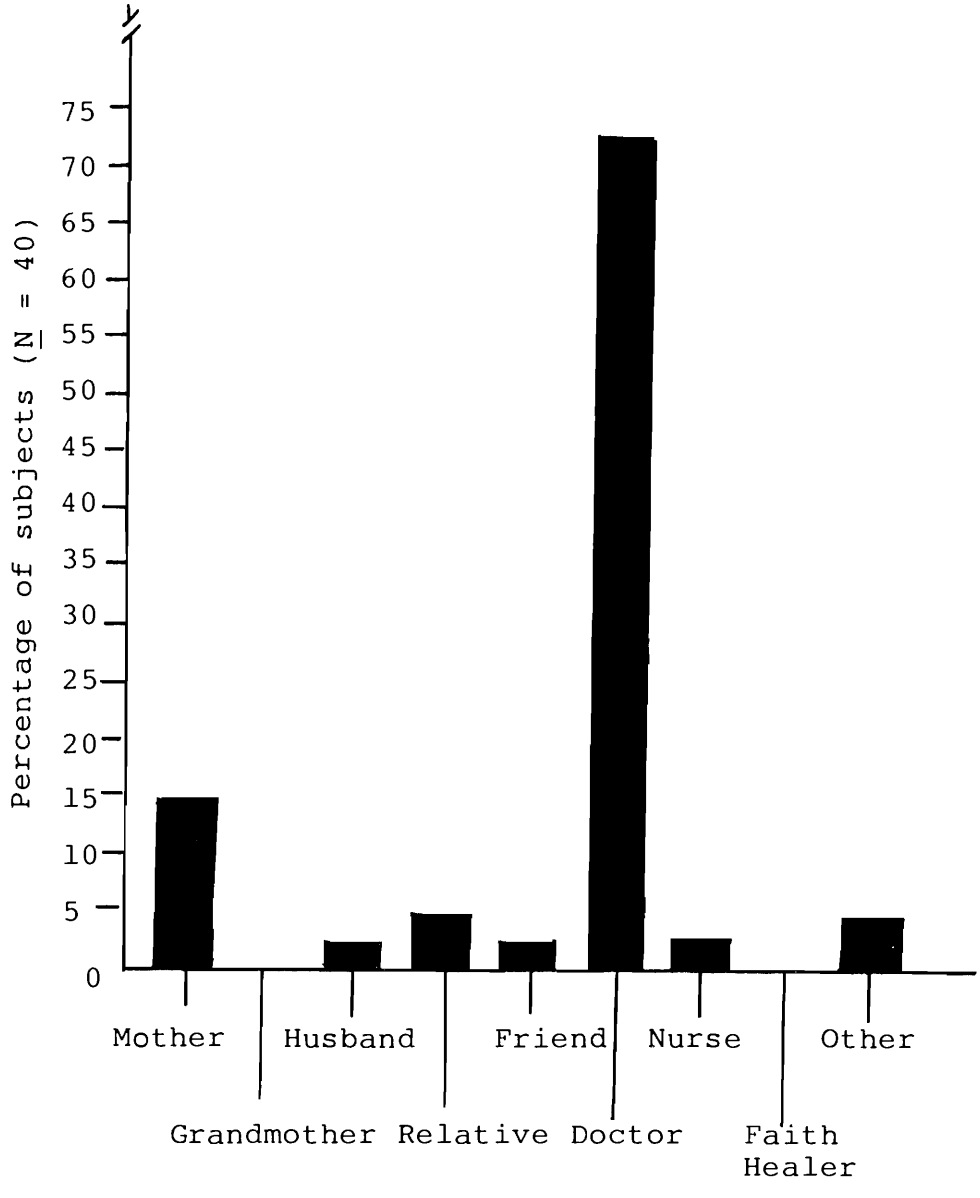

Figure 4. Sources of preferred pregnancy advice as reported by sample (N = 40). Subjects could select all that apply.

Table 2

Responses of Women in Interview Sample to Questions Regarding Self-Care, Nutrition and Medication During Pregnancy (N = 40)

Question	Response	Source	No.
Are there any special things that you should do when you are pregnant?	Exercise	Book	3
		Mother	1
		Friend	1
		Doctor	3
		Relative	1
		Self	5
		WIC	1
	Eat Well	Prenatal class	1
		Self	4
		Book	2
		Friend	1
		Doctor	2
		WIC	2
	Rest	Prenatal class	1
		Doctor	3
		WIC	1
	Get check-ups as soon as possible	Mother	1
		Prenatal class	1
		Doctor	3
		Grandmother	1
	Watch weight (so baby will not get too big)	Doctor	2
		Self	1

Table 2 continued

Question	Response	Source	No.
	Bathe daily	Relative	1
	Make clothes/ supplies	Doctor	1
	Nothing special	Self	12
Are there any things you should avoid doing when you are pregnant?	Heavy lifting, strenuous activities	Doctor	9
		Relative	1
		Midwife	1
		Self	7
		Prenatal class	1
		Husband	2
		Mother	3
		Book	1
		Everyone	2
	Running, bouncing	Doctor	2
	Drinking	Self	2
		Book	3
		Doctor	4
		Mother	1
		Everyone	1
		Relative	1
	Smoking	Self	3
		Book	3
		Doctor	5
		Mother	1
		Everyone	2
	Drugs	Self	1
		Book	1
	Limit Intercourse	Everyone	1

Table 2 continued

Question	Response	Source	No.
	Douching	Everyone	1
	Nothing	Self	5
Are there any foods that it is important to eat when you are pregnant?	Milk, Dairy	Doctor	8
		Mother	1
		WIC	6
		Nurse	1
		School	1
		Self	2
		Book	1
	Basic 4	Doctor	1
		WIC	8
		School	2
		Self	2
		Prenatal class	1
		Young mother	1
	Fruits only	Doctor	4
		Nurse	1
		School	1
		Self	1
		WIC	1
		Book	1
	Vegetables only	School	1
		WIC	1
		Book	3
		Doctor	4
	Foods high in iron	Mother	1
		Doctor	2
		Self	1
		Book	1
	Foods craved	Self	2

Table 2 continued

Question	Response	Source	No.
	Eggs	Doctor	2
		Nurse	1
		WIC	3
	Meat	School	1
		WIC	1
		Doctor	3
		Book	2
		Self	1
	Everything	Self	4
	Cereal	WIC	1
Are there any foods that it is important to avoid eating when pregnant?	Alcohol	Doctor	1
		WIC	1
	Greasy foods	Doctor	3
		WIC	5
		Sister	1
		Self	2
	Anything that causes indiges-tion	Self	1
	Bread, potatoes, starch	Self	2
		WIC	1
	Junk food	WIC	5
		Doctor	3
	Salt (extra)	WIC	2
		Husband	1
		Relative	1
		Doctor	4
		Self	2

Table 2 continued

Question	Response	Source	No.
	Sugar	WIC	5
		Doctor	3
		Self	3
	Chili, spicy food (causes rash in baby)	Husband	1
		Relative	1
		Self	2
		Sister	1
		Friend	1
		WIC	1
	Tea, coffee	Doctor	1
	Lemon (causes low blood)	Mother	1
	Too much (so baby will not get so big)	Self	2
Are there any herbs, medicines or remedies that it is important to take when you are pregnant?	Vitamins	Nurse	1
		Self	2
		Doctor	22
		WIC	2
	Iron	Self	2
		WIC	2
		Prenatal class	1
		Doctor	8
	Herb Tea (Chamomile, Cinnamon, Red Raspberry, Rose hip)	Self	2
		Relative	1
		Mother	2
		Doctor	1
	Calcium	Doctor	2

Table 2 continued

Question	Response	Source	No.
	Nothing	Self	4
Are there any herbs, medicines or remedies that it is important to avoid taking when you are pregnant?	Aspirin	Nurse	1
		Mother	3
		Self	3
		Prenatal class	1
		Friend	1
		Relative	2
		Doctor	11
		Book	2
	Strong Medicines, Diet pills	Nurse	1
		Doctor	2
	Birth control	Mother	1
		Doctor	1
	Things you are allergic sensitive to	Doctor	1
		Self	2
	Laxatives	Doctor	1
	Meds not prescribed by doctor	Mother	1
		Self	3
		Prenatal class	1
		Doctor	11
	Hard drugs	Doctor	5
		School	1
		Self	2
	Home remedies	Self	2
		Prenatal class	1
		Midwife	1
	No	Self	3

of information for women in the sample.

Nutrition and medication during pregnancy were the two areas in which doctors seemed to have provided information which the women remembered. In terms of nutrition, eight women (20%) reported that doctors told them to drink milk. Doctors, however, did not seem to be a major force in encouraging a balanced diet. The WIC program provided the women with the most complete dietary information. A discussion of the impact of the WIC program as documented among the Interview Sample will be provided in a subsequent section.

The medication most insisted upon by physicians was prenatal vitamins; 22 women (55%) stated that their doctors had told them to take the vitamins. It is apparent from the number of women giving this response that the women are capable of learning things they are told by their care provider. The fact that only 11 women (25%) noted that their doctors had told them to avoid aspirin (the greatest number of subjects recalling any other single piece of information) indicates that the women are not consistently being provided information about self-care during pregnancy by their doctors.

Regarding self-care during pregnancy, women most

frequently remembered that doctors told them to avoid heavy lifting and strenuous exercise. It would seem that the majority of the information that women receive from physicians is negative (i.e., "do not take aspirin," or "avoid heavy lifting"). Such advice given consistently would seem to promote the attitude among a client population that pregnancy is a time for restricting life activities or possible dangers rather than actively taking steps to improve their health and that of their babies.

The most consistent information source for all areas concerning self-care was reported by the women in the sample to be their own experience and knowledge (self). The most frequent response to the self-care questions by women who relied on their own experience was "nothing special." It is apparent that there is a need for a source of consistent, understandable information regarding care of self and the growing baby during pregnancy. Such information should provide both positive (things which the woman can do) and negative (things which the woman should avoid doing) aspects of such care.

Pregnancy was a fairly common subject of conversation among the Interview Sample. Thirty-three women (62.5%) stated that they had female family members who

talked with them about their own previous pregnancies. Thirty-five women (67.5%) stated that female family members gave them advice about pregnancy (this advice included the need for prenatal care--39 (97.5%) women said that the women in their families felt that prenatal care was important). Thirty-six women (92.5%) stated that they frequently discussed pregnancy with family members.

Friends were also included in conversations about pregnancy. Thirty-one (77.5%) of the subjects had friends who were currently pregnant or who had been pregnant since they had known them. Thirty-three women (80%) said they talked to their friends about pregnancy; 29 (72.5%) stated their friends gave them advice about pregnancy. Since friends and family were apparently major support systems in terms of providing information and advice regarding pregnancy, the availability of such groups is an important factor to be considered.

Twenty-one women (53.5%) in the sample lived in households of five persons or more. Seventeen lived in homes with two or three other people. Only two lived with only a single child. Most frequently, the others in the home were children and the husband or boyfriend. Other relatives who were also mentioned

as sharing the home most often included mother and sisters.

Thirty-seven women (92.5%) had relatives living within 50 miles of their current residence, and 32 (80%) had friends in their neighborhoods. Thirty women (75%) stated that if they had family members living far away they could talk with them at least weekly by telephone. Five reported monthly contact was possible, three stated that they were seldom able to talk to distant family members by phone, and two women (5%) reported they never called their families. Only five (12.5%) of the women seldom or never visited their families, five were also able to visit monthly or at least yearly, and 30 women (75%) did so weekly. Twenty-five women (62.5%) in the Interview Sample were able to visit with friends at least weekly. Five women (12.5%) saw their friends every month, and 10 (25%) of the subjects stated they saw or visited with their friends yearly or less frequently.

Husbands or boyfriends also provided support and information. Twenty-nine women (72.5%) said that their partners talked with them about pregnancy. Twenty-seven (67.5%) stated their husbands or boyfriends tried to spend more time with them when they were pregnant. Twenty-six women (65%) felt that if they

had gone to prenatal classes, their partners would have accompanied them. Thirty-six women (90%) reported that the father of their last baby felt that professional prenatal care was important.

Information received from various sources regarding pregnancy and its possible consequences was not always internalized by the women in the sample, however. Twenty-five (62.5%) of the subjects said that women in their families had told them of problems related to their own pregnancies. Such information would give the subjects an awareness of the potential severity of pregnancy. Eleven women (27.5%) had been told by their doctor that there was some problem with their most recent pregnancy. This would have identified to the women their susceptibility to problems related to pregnancy. However, only nine of the women for whom problems were actually diagnosed felt that there really were problems with their last pregnancy.

There are two possible reasons for this response, both of which can be related to aspects of the Health Belief Model. First, it is possible that the women, though informed of an existing problem, did not experience any overt physical symptoms and thus did not really believe that they were compromised in any way. If this was the reason that the women did not feel

that there were any problems with a pregnancy when their doctors had, in fact, informed them that such problems did exist; it is apparent that the women in the Interview Sample believe that one must actually feel sick in order to be considered sick. This being the case, it is evident that client education regarding the potential severity of pregnancy complications, even in the absence of delibitating symptoms, and the need for regular professional prenatal care to prevent or minimize those complications, is greatly needed among the Hispanic population of the Weber-Morgan District.

The second possible explanation for some subjects' denial of problems with their pregnancies is that despite the fact that they might have experienced symptoms, they may have felt either that the symptoms did not indicate a serious problem or that the symptoms were to be expected during pregnancy, and that there was little to be done to prevent or relieve them. These attitudes reflect the cultural orientation of the women in the sample, and also indicate a need for client education. According to the precepts of the Health Belief Model, the woman must believe that the problems of pregnancy are potentially severe, that they are susceptible to those problems in the

absence of overt symptoms, and that there is something that they can do to reduce either the severity of the problems or their susceptibility to the problems (i.e., seeking adequate prenatal care).

While it can be noted from the questions dealing with self-care during pregnancy that women in the sample did not have a consistent or complete knowledge base or adequately reliable sources of information, it is evident that most of the women have well developed social support systems. These support systems tend to consist of significant others (either family or friends) who provide information and social interaction supportive of the pregnant woman. According to the Health Belief Model, social pressure is a factor influencing an individual's health care choices. It is also one factor which Rosenstock (1974) suggested can be manipulated. Perhaps an intense, community-wide effort to educate friends, relatives, and partners, as well as the women themselves, might result in more pressure from these persons in support groups to encourage pregnant women to seek adequate prenatal care.

From the results discussed in this section, it can be concluded that the women of the Interview Sample did not desire to avoid the prenatal care system.

Rather, the services, although available in the Weber-Morgan District, are not obtainable by most of the women for reasons related to cost of services and distance from facilities. Modesty, a cultural characteristic of Mexican American women, also may be implicated as a reason for limiting contact with physicians.

Another conclusion that can be drawn is that the low-cost services available through the Health Department are valuable in a number of ways. The information provided by the WIC program, for example, was found to be among the most complete and consistent reflected in the subjects' responses. Furthermore, the WIC program exposed the women to the availability of other services and encouraged participation in those programs (i.e., Immunizations, Family Planning, and Child Health Conference).

Finally, the existence of an informal social support system was verified by the results presented in this section. This finding supports the conclusions of most previous researchers.

The need for a consistent source of usable information regarding pregnancy is apparent. Such an information source must be readily available to the Hispanic women of the Weber-Morgan District. The success of

the WIC program noted earlier suggests that a low-cost service provided by the Health Department might be most effective in filling this need.

Research Question Three

Research question three stated:

> What changes could be made so that prenatal care would be more appealing to Hispanic women?

Section 2 of the interview schedule presented a number of possible characteristics of an hypothetical prenatal care service. The subjects were asked to rate each factor according to whether they felt it to be very important, important, or not important (Table 3). The results of the ratings provide a description of those aspects of a health care service deemed most and least desirable by the women of the Interview Sample.

Although most of the women in the Interview Sample considered English to be their primary language, more than half of them considered it to be very important that a health care service make provisions for those who do not speak English. Eighty percent felt that at least some of the care providers should speak Spanish. Spanish prenatal classes and information booklets were also rated as very important by 52.5% of the women. This reflects a sense of understanding

Table 3

List of Preferred Characteristics of an Hypothetical Prenatal Care Service in Order of Importance to the Sample Population

(N = 40)

Characteristic	Ranking	Percentage Assigning Rank
1. Located in central city area	Very Important	82.0%
2. Some care provider should speak Spanish		80.0%
3. The service should offer health care for the entire family		75.0%
4. All information about patients should be kept confidential		67.5%
5. The service should accept small fees according to one's ability to pay		60.0%
6. The service should be a pleasant, relaxed place with friendly people		60.0%
7. The service should accept medicaid payments		55.0%
8. The service should be located on a bus route		55.0%

Table 3 continued

Characteristic	Ranking	Percentage Assigning Rank
9. Spanish language information booklets should be available	Very Important	52.5%
10. The service should offer prenatal classes in Spanish		52.5%
11. Care providers should be both men and women		50.0%
12. The service should offer child care		50.0%
13. Care should be offered to people whether or not they are U.S. citizens		50.0%
14. Patients should not have to wait more than 15 minutes before seeing a care provider		50.0%
15. The service should accept private insurance payments	Very Important Important	42.5% 42.5%
16. The service should be free	Important	62.5%[a]
17. The service should only care for women's needs	Not Important	57.5%
18. All care providers should be women		70.0%
19. The service should only care for pregnant women		77.5%

Table 3 continued

Characteristic	Ranking	Percentage Assigning Rank
20. All care providers should speak Spanish	Not Important	77.5%
21. All care providers should be men		92.5%

Note. [a]Percentages begin to increase because ranking criteria change.

of the problems resulting from language difficulties, even if the subjects themselves had not experienced those difficulties.

It seemed to be very important to the women that a service which offers health care should not specialize (it was considered to be not important that the hypothetical service offer health care just for pregnant women or women's needs in general), but rather offer care for the whole family. This would provide a sense of continuity, and also minimize the amount of commuting to various different locations for health care.

Another attitude of the women is illustrated by their responses to other items. Sixty percent of the women indicated that a prenatal care service should charge small fees according to one's ability to pay. This reflects a willingness to pay for health care services but emphasizes the difficulty many Hispanic families have in affording such services. A number of women (62.5%) indicated that it would be important for the service to be free. This seemed to reflect a feeling of sympathy for those who were unable to afford health care rather than an unwillingness to pay for professional services.

Finally, it is interesting to note that most of the subjects in the Interview Sample indicated

that health care providers should be both men and women (50% rated this as very important). It would seem that while the women would prefer not to be subjected to physical examination by a male physician, a man's presence as a health care provider gives a sense of security.

Some of the characteristics mentioned as being very important by the women might be found in any prenatal care service. These include confidentiality of client records and possibly the availability of Spanish information booklets. A number of providers (but not all) may accept Medicaid patients. A community health facility, such as the Ogden Community Clinic (see Appendix B), would be more likely to accept low-income patients, and would be able to provide health care for the entire family. The Ogden Community Clinic is also located in the favored central city area. The only provider of prenatal care in the Ogden area who speaks Spanish is employed at the Ogden Community Clinic.

At the time of this study, no prenatal care services were offered on a sliding-scale fee basis. While it is unrealistic to anticipate a completely free service for all clients, a service which was free to women who could not pay might attract such

women early in their pregnancies when such care would be of the most value. Those women frequently wait until later in their pregnancies to receive care in the hope that fewer visits will result in a lower cost. This is unrealistic as most prenatal care is usually offered as a package, that is, the cost is the same no matter how many or how few visits are made.

Several women had suggestions to make in addition to those noted on the list. These included: the area should be clean and comfortable; staff members should be friendly, patient and present a neat appearance; adequate ventilation of waiting areas is important; prenatal classes should be offered in both English and Spanish; and it would be helpful if someone could come to clients' homes and transport them to the clinic if they had no other way to get to their appointments.

Several other suggestions were made. Play areas for children were suggested by several women, and some stated that supervision of such areas would be nice so that they would not have to bring their children into the examination rooms with them. The women stated that they would like to have current magazines or information booklets to read while waiting to be seen. It was suggested that a child-sized water fountain

would reduce the necessity for pregnant women to lift older, heavy children. Finally, one woman complained that staff members were frequently heard gossiping about patients at the facility that she had utilized for prenatal care, and stated that such behavior should not be allowed.

The purpose of asking the women of the Interview Sample to rate characteristics of a prenatal care service was twofold. First, it provided the women direct input into the health care system. Frequently, health care providers attempt to determine the needs of a community using available statistical data and then plan to meet identified needs in an arbitrary fashion. Services developed using such impersonal planning strategies may outwardly appear to meet specified needs; however, they may not be utilized if in some less obvious respect they are not acceptable to the local population. This study involved interviews with recipients of care in order to provide personal input regarding the most acceptable means of meeting prenatal care needs.

The second purpose of this section of the interview was to provide the women with a sense (however small) of some control over a system which may have been perceived as unresponsive to personal input. If the

recommendations of the women are considered in the establishment of a prenatal care service, a number of perceived barriers to professional care might be eliminated.

In summary, this section of the interview allowed women to express their own feelings and desires regarding various aspects of prenatal care services. The women identified those aspects which were most important in a prenatal health care service, including location in the central city area (where the greatest concentration of Hispanics in the Weber-Morgan District is located), low cost, availability of care providers fluent in Spanish, and availability of a full range of health care in a single location. An all-male staff of health care providers was rated of least importance as a characteristic of a health care service. Other more specific suggestions also were made by subjects. A service which utilizes the findings from this investigation in establishing and providing care should be more attractive to the Hispanic population in the Ogden area than those available at the time of this study.

Other Data

Language

Seventy percent of the women in the Interview Sample considered their primary language to be English; 12 of the women (30%) stated that their primary language was Spanish. At the time of the study, however, only six women (15%) spoke so little English that the interview had to be conducted in Spanish. Eleven of the women (27.5%) spoke no other language in addition to their primary language. When asked which language was spoken at home, 60% of the women stated that English was spoken in their home. Eight women (20%) said that both languages were spoken, and six (15%) said that only Spanish was spoken in their homes (Figure 5).

Locus of Control

Locus of control was tested with the Childbearing Health Locus of Control instrument developed and validated by Foster (1981). Scales on Internality, Fate/Chance, and Powerful Others, comprising a total of 20 questions, were included in Section 3 of the interview schedule. These questions initially seemed to be confusing to subjects because the questions required the women to evaluate their own feelings rather than

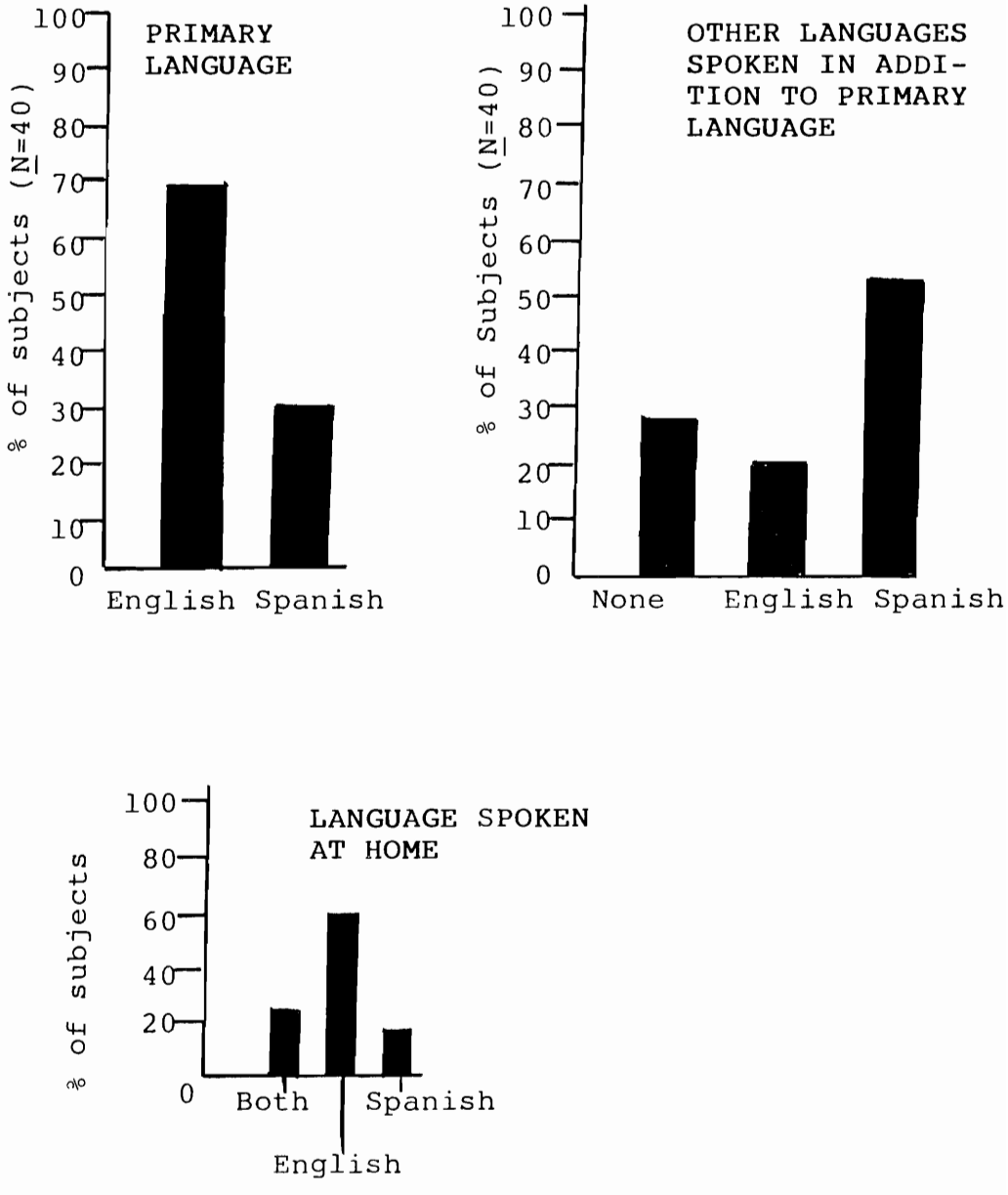

Figure 5. Language use of study sample.

simply state a fact. Once the object of the questions was clarified for the women ("there are no right or wrong answers--I just want to know if you personally agree or disagree with these statements"), they were able to answer without difficulty.

The results of the scoring of this section may be reviewed in Table 4. Table 4 also reports the normative data as determined from Utah primigravid women (Foster, 1981).

In two of the sections dealing with internality and fate/chance, the Hispanic women in the Interview Sample scored more than twice as high in the direction of externality as the Utah women with whom the tool was validated. According to the locus of control scoring, it is apparent that the Hispanic women of the Interview Sample believe themselves to have less control over the childbearing experience than the original sample of Utah primigravid women. This is consistent with the observation by Phares (1976) noted earlier in this study: that Hispanics tend to exhibit a more external locus of control than the general population.

The scores of each scale (Internality, Fate/Chance, and Powerful Others) of Section 3 correlated highly with each of the other scales (using Pearson *r* corre-

Table 4

Childbearing Health Locus of Control

	Hispanic Women Weber County, Utah, Mixed Parity (N=40)	Utah Primigravidae Normative Data[a] (N=255)
Internality Scale		
N of domain items	6.0	6.0
Mean number of items in scored direction	1.2	.53
Standard deviation	1.09	.84
Range	0-4	Not Available
Alpha coefficient of scale	Not Available	.40
Externality: Powerful others Scale		
N of domain items	8.0	8.0
Mean number of items in scored direction	4.78	4.22
Standard deviation	2.21	2.27
Range	0-8	Not Available
Alpha coefficient of scale	Not Available	.74
Externality: Fate/ Chance Scale		
N of domain items	6.0	6.0
Mean number of items in scored direction	3.2	1.58
Standard deviation	1.80	1.21
Range	0-6	Not Available
Alpha coefficient of scale	Not Available	.39
Combined Locus of Control Scale		
N of domain items	20.0	20.0
Mean number of items in scored direction	9.18	6.32
Standard deviation	3.77	3.17
Range	2-17	Not Available
Alpha coefficient of scale	Not Available	.71

Note. [a]Foster, 1981.

lations) and with the total of all of the scales. When the locus of control scores were compared with various characteristics of the sample group (primary language and language spoken at home to represent cultural background, age, education, and income levels), no statistically significant ($p < .05$) correlations emerged. Thus it would seem that, among this sample, no single factor or group of factors is responsible for the external orientation of Hispanics.

As noted above, the women of the Interview Sample were found to have a much more external orientation than the normative population on two of the three subscales (Internality and Fate/Chance). On the third subscale (Powerful Others), however, the two groups had nearly identical scores. Furthermore, the scores were much more in the direction of externality (even for the Utah primigravid women) than for either of the other subscales. It is possible that this indicates a tendency on the part of health care providers as a group to foster a sense of dependence among the general population of childbearing women in order to perpetuate a demand for their services. This is supported, at least among the Hispanic women in the Interview Sample, by the apparent lack of consistent information provided by health care professionals--infor-

mation which might allow or encourage the women to assume a more active role in their own health care during pregnancy.

Information Seeking Practices

Table 5 illustrates the patterns of media usage by the sample group. Books and the newspaper were least preferred as sources of information. Sixty percent of the women stated that they only "sometimes" or "never" read books for the purpose of obtaining information. Sixty-five percent only sometimes or never read the newspaper. The most popular source of information was television, which 70% of the women reported watching always or often.

Only five women reported that they belonged to a community organization through which they could obtain information. When asked how they learned of services which were available in their community, the majority of the women in the sample (25 or 62%) stated that they were most likely to learn of such services by word of mouth from friends and relatives who comprised their support systems.

It is important to understand the information-seeking practices of a population if education on a community-wide scale is planned. When the preferences of the Interview Sample are considered, it would seem

Table 5

Information Seeking Practices (N = 40)

Information Question	Always	Often	Some-times	Never
Do you read the newspaper?	10 (25%)	4 (10%)	18 (45%)	8 (20%)
Do you listen to radio news?	13 (32.5%)	6 (15%)	15 (37.5%)	6 (15%)
Do you watch TV news?	21 (52.5%)	7 (17.5%)	11 (27.5%)	1 (2.5%)
Do you read books for information?	5 (12.5%)	11 (27.5%)	15 (37.5%)	9 (22.5%)

probable that the most effective means of reaching the population of Hispanic childbearing women for the purpose of education might be frequent short public service announcements or advertisements on television regarding the importance of adequate prenatal care and the availability of services to provide such care. Appropriate services could also make good use of the reliance of word-of-mouth for the dissemination of information by encouraging present clients to speak with friends and relatives about the various types of care available.

Prenatal classes and books or pamphlets about pregnancy are also available information sources. Thirty-four of the women (85%) felt that it would be helpful to read books about pregnancy--29 (72.5 %) had actually read such books. Thirty women thought that prenatal classes, which are available at varying costs in the Ogden area, would be helpful; however, only 19 of the women in the sample reported having attended classes. Prenatal classes offered at little or no cost to the client through the agency at which she receives her prenatal care, and which classes she is encouraged to attent, might have higher participation rates than classes offered by private individuals.

Use of Weber-Morgan District Health Department Services

Figure 6 shows some of the services offered by WMDHD. It can be noted that 85% of the women were enrolled in the WIC program and 60% had utilized the Immunization clinic. Other services used included Child Health Conference (25%), Family Planning (22.5%), and Young Mothers (15%). Fewer than 10% of the women used each of the following services: Cervical Cancer, High Risk Referral, Infant Development, and the Tuberculosis clinic.

The relatively high participation in these programs conflicts somewhat with the findings of this study, which indicate that the women are not likely to perceive a need for health care in the absence of symptoms. It is probable that when the women come to the Health Department, as required by the WIC programs, they are encouraged to participate in the other services as well. This reemphasizes the importance of WIC, which has already been noted to provide consistent, quality information regarding nutrition to pregnant women.

Summary

Several important points have emerged from the data analysis described in this chapter. Most of

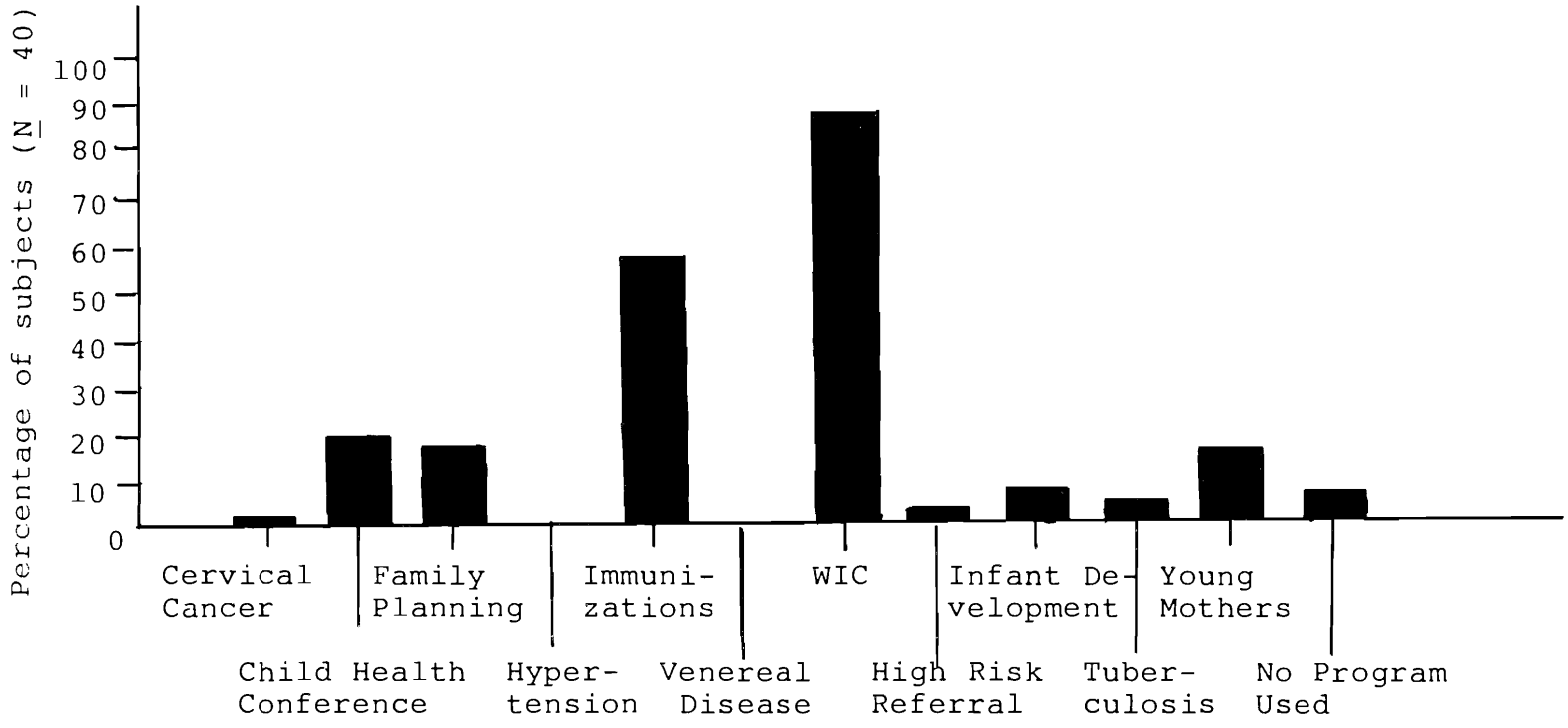

Figure 6. Weber-Morgan district health department services utilized by subjects.

the women interviewed reported having an adequate number of prenatal care visits (despite information to the contrary recorded on Birth Certificates) and being satisfied with the amount of care received. Reasons most frequently given for not receiving more care were varied and included cost of care, lack of transportation, and modesty.

The majority of the subjects stated that they would prefer to go to their doctors for information and advice concerning pregnancy. While many of the women stated that they did receive most pregnancy-related information from doctors, physicians were shown not to be a consistent source of adequate information regarding pregnancy. Most women did have well-developed informal networks of friends and/or relatives who provided social support and information.

Several factors were noted by the women to be desirable in a prenatal care service. These factors included location in an accessible area of town, low cost, availability of Spanish-speaking health care providers, and the availability of a full range of health care services in a single location. While the women preferred to avoid physical examinations by a male care provider, the presence of male staff seemed to offer a sense of security.

The Hispanic women of the sample were found to be more externally oriented in terms of childbearing locus of control than a normative group of Utah primigravid women. Both the women in this sample and the Utah primigravid women demonstrated a somewhat highly external orientation toward powerful others (including health care providers) involved with childbearing.

Most of the women in the Interview Sample considered English to be their primary language. They reported a limited belief in the traditional folk health system, and reportedly did not use folk health care practitioners. Preferred information sources included television and word of mouth.

Many of the women interviewed utilized services already offered by the Weber-Morgan District Health Department. The most widely-used of these services was the WIC program. This program provided excellent and consistent information and exposed the women to other services which were available for their use.

The results of this study indicate areas of information which will assist health care agencies to better understand the prenatal care needs and preferences of those Hispanic women who seem to avoid the established medical system. Such knowledge should contribute

to the development of services which would be more attractive to the Hispanic population.

CHAPTER IV

CONCLUSIONS AND DISCUSSION

This study has used the Health Belief Model in association with an interview schedule to examine the reasons for which women of Hispanic origin residing in Weber county are more likely to receive inadequate prenatal care than Anglo women from the same area. The data indicate that Hispanic women have a somewhat limited understanding of the importance of their own actions in assuring a healthy outcome of pregnancy for mother and baby. Their understanding and knowledge base was not greatly increased by information received from doctors or other health care professionals. Several perceived barriers to receiving more prenatal care were also identified. These include cost, inconvenience, and problems relating to modesty. Folk health care practices were not reported as interfering significantly with prenatal care.

The majority of the women interviewed, however, did seem to be aware of the importance of prenatal care which is regular and initiated early in pregnancy.

This knowledge base will provide a valuable starting point for agencies wishing to improve usage of prenatal care facilities by the Hispanic population.

The Weber-Morgan District Health Department is ideally situated to provide prenatal care in that it is located in the central part of Ogden (the site favored by most subjects) and is located on a bus route. The Health Department already offers various programs which benefit all age groups; many women interviewed were, in fact, using one or more of these programs. Furthermore, Health Department services are offered on a sliding scale basis, making it easier for low-income families to obtain the services.

Several factors might be considered when establishing a prenatal care service at the Health Department. Appointments should be scheduled to result in a minimum waiting period for the client. If possible, care providers should be available who are fluent in Spanish; if not, translators should be immediately available at the service. Magazines and information booklets should be available in the waiting area. Prenatal classes in English and Spanish should be developed and offered by the Health Department.

The selection of an appropriate health care professional to provide prenatal care is also essential.

Current plans are to utilize a Certified Nurse-Midwife in this capacity; prenatal care will be provided at the Health Department and delivery will be managed by a local obstetrician under contract with the Health Department. All provider costs will be available to clients on a sliding-scale basis; hospital costs will not be affected or reduced in any way by the program.

There are several benefits to using a Certified Nurse-Midwife (CNM) to provide prenatal care. Of major importance is the lower cost to the community of paying a CNM rather than a physician. Nurse-Midwives are specialists in nutritional counseling for pregnancy, as well as other aspects of client education. They encourage client participation in, and responsibility for, effective prenatal health care and health practices. While not all CNMs are women, use of a female practitioner might best reduce the clients' embarrassment regarding necessary physical examinations.

Establishment of a prenatal care service at the Weber-Morgan District Health Department using a Certified Nurse-Midwife as the primary care provider should, according to the Health Belief Model, improve the compliance of Hispanics with currently acceptable levels of such care. This will be accomplished both

by removal or minimization of perceived barriers to prenatal care, and by educating women regarding the benefits of prenatal care in reducing or eliminating health problems arising during pregnancy.

Recommendations for Further Research

Use of the instrument among various populations by other investigators will assist in establishing its reliability. Internal validity would be enhanced if consistent results were obtained with a larger sample (at least 80).

Use of the instrument among populations of various socioeconomic and/or cultural orientations, while controlling for other factors, could provide information regarding which factor, if any, has the most effect on women's choices concerning prenatal care.

Finally, it might be of interest to repeat this study among a sample population of local Hispanic women at a future date, to assess the impact of the new prenatal care service in providing information and improving client compliance with acceptable standards of prenatal care.

Caution should be taken by any researcher duplicating this research or other investigations which utilize information on Birth Certificates for descrip-

tive data. It has been observed that data appearing on these public records are not always consistent with data reported. Perhaps research regarding recording techniques would be in order, with the possible long-range goal of developing a consistent and accurate method of data recording. In addition, further study is indicated to verify the accuracy of recall in verbal reports of childbearing women regarding Birth Certificate information.

APPENDIX A

QUESTIONNAIRES

These questions are designed to be used with optical scan sheets. All responses to questions with Arabic numbering are recorded on the optical scan sheet. All responses to questions preceded by Roman numberals are recorded on a worksheet. Identification numbers and subjects' education levels are recorded in the appropriate spaces on the optical scan sheet.

I. Beliefs Concerning the Seeking of Health Care and Advice About Health Care

1. Do you have a family doctor?
   a. yes (_____)
   b. no Date last seen

2. Do you go to any clinic or health service?
   a. yes (specify_____)
   b. no

Do you or have you used any of the health care services offered by the Weber-Morgan District Health Department in the last 5 years?

3. Cervical Cancer
   a. yes _____(when)
   b. no

4. Child Health Conference
   a. yes
   b. no

5. Family Planning
   a. yes
   b. no

6. Hypertension
   a. yes
   b. no

7. Immunizations
   a. yes
   b. no

8. Venereal Disease
   a. yes
   b. no

9. WIC
   a. yes
   b. no

10. High Risk Referral
    a. yes
    b. no

11. Infant Development
    a. yes
    b. no

12. Tuberculosis
    a. yes
    b. no

13. Young Mothers
    a. yes
    b. no

14. Was anyone in your family sick in the past six months?
    a. yes
    b. no

IA. Please list all family members who have been sick in the past six months.

_____

_____

15. Did they receive care outside the home?
    a. yes
    b. no
    c. n/a

IB. Where did that person/those people go for health care?

_____

16. When is it important to seek health care?
    a. At least once a year whether one feels sick or not
    b. Only when one is unable to do his/her work
    c. As soon as one feels sick
    d. Other_____

When you get sick or have family problems related to your sickness, to whom do you go first for advice and help?

17. Mother
    a. yes
    b. no

18. Grandmother
    a. yes
    b. no

19. Relative
    a. yes
    b. no

20. Friends
    a. yes
    b. no

21. Nurse
    a. yes
    b. no

22. Doctor
    a. yes
    b. no

23. Faith Healer
    a. yes
    b. no

24. Other (_____)

What other people do you go to for advice and help?
(Check all that apply)

25. Mother
    a. yes
    b. no

26. Grandmother
    a. yes
    b. no

27. Relative
    a. yes
    b. no

28. Friends
    a. yes
    b. no

29. Nurse
    a. yes
    b. no

30. Doctor
    a. yes
    b. no

31. Faith Healer
    a. yes
    b. no

32. Other (_____)

When you get pregnant or have family problems related to your pregnancy, to whom do you go first for and help?

33. Mother
    a. yes
    b. no

34. Grandmother
    a. yes
    b. no

35. Relative
    a. yes
    b. no

36. Friends
    a. yes
    b. no

37. Nurse
    a. yes
    b. no

38. Doctor
    a. yes
    b. no

39. Faith Healer
    a. yes
    b. no

40. Other (_____)

The following questions deal specifically with your last pregnancy.

41. How did you know that you were pregnant?
    a. Missed one or more periods
    b. Felt nauseated
    c. Went to family member or relative (_____)
    d. Went to doctor or clinic (_____)
    e. Other (_____)

IC. When you found out you were pregnant, who did you tell? (Please number all that apply in the order that they were told, with "1" being the first person you told).
    a. Husband

b. Mother
c. Relative (_____)
d. Friend
e. Other (_____)

If you have any questions about pregnancy, who do you talk to?
(Please check all that apply)

42. Mother
a. yes
b. no

43. Grandmother
a. yes
b. no

44. Husband
a. yes
b. no

45. Relative (_____)
a. yes
b. no

46. Friend
a. yes
b. no

47. Doctor
a. yes
b. no

48. Nurse
a. yes
b. no

49. Faith Healer
a. yes
b. no

50. Other (_____)

Whose advice do you prefer to take about what you should or should not do when you are pregnant?

51. Mother
a. yes
b. no

52. Grandmother
    a. yes
    b. no

53. Husband
    a. yes
    b. no

54. Relative (_____)
    a. yes
    b. no

55. Friend
    a. yes
    b. no

56. Doctor
    a. yes
    b. no

57. Nurse
    a. yes
    b. no

58. Faith Healer
    a. yes
    b. no

59. Book or other Media
    a. yes
    b. no

60. Other (_____)
    a. yes
    b. no

ID. Are there any special things that you should do when you are pregnant? (Please list and/or describe and tell me in your own words why each item listed is important).

_____
_____
_____

From whom did you get that information?

61. Mother
    a. yes
    b. no

62. Grandmother
    a. yes
    b. no

63. Husband
    a. yes
    b. no

64. Relative (_____)
    a. yes
    b. no

65. Friend
    a. yes
    b. no

66. Doctor
    a. yes
    b. no

67. Nurse
    a. yes
    b. no

68. Faith Healer
    a. yes
    b. no

69. Book or other media (_____)
    a. yes
    b. no

70. Other (_____)
    a. yes
    b. no

IE. Are there any things that you should avoid doing when you are pregnant? (Please list and/or describe, and tell me in your own words why each is important).

_____

_____

_____

Where did you get that information?

71. Mother
    a. yes
    b. no

72. Grandmother
    a. yes
    b. no

73. Husband
    a. yes
    b. no

74. Relative (_____)
    a. yes
    b. no

75. Friend
    a. yes
    b. no

76. Doctor
    a. yes
    b. no

77. Nurse
    a. yes
    b. no

78. Faith Healer
    a. yes
    b. no

79. Book or other media (_____)
    a. yes
    b. no

80. Other (_____
    a. yes
    b. no

IF. Are there any foods that it is important to eat when you are pregnant? (Please list and tell me in your own words why each is important).

_____

_____

_____

Where did you get that information?

81. Mother
    a. yes
    b. no

82. Grandmother
    a. yes
    b. no

83. Husband
    a. yes
    b. no

84. Relative (_____)
    a. yes
    b. no

85. Friend
    a. yes
    b. no

86. Doctor
    a. yes
    b. no

87. Nurse
    a. yes
    b. no

88. Faith Healer
    a. yes
    b. no

89. Book or other media (_____)
    a. yes
    b. no

90. Other (_____)
    a. yes
    b. no

IG. Are there any foods that it is important to avoid eating when you are pregnant? (Please list and tell me in your own words why each is important).

_____
_____
_____

Where did you get that information?

91. Mother
    a. yes
    b. no

92. Grandmother
    a. yes
    b. no

93. Husband
    a. yes
    b. no

94. Relative (_____)
    a. yes
    b. no

95. Friend
    a. yes
    b. no

96. Doctor
    a. yes
    b. no

97. Nurse
    a. yes
    b. no

98. Faith Healer
    a. yes
    b. no

99. Book or other media (_____)
    a. yes
    b. no

100. Other (_____)
    a. yes
    b. no

IH. Are there any herbs, medicines, or remedies that it is important to take when you are pregnant? (Please list and tell me in your own words why each is important).

_____

_____

_____

Where did you get that information?

101. Mother
    a. yes
    b. no

102. Grandmother
   a. yes
   b. no

103. Husband
   a. yes
   b. no

104. Relative (_____)
   a. yes
   b. no

105. Friend
   a. yes
   b. no

106. Doctor
   a. yes
   b. no

107. Nurse
   a. yes
   b. no

108. Faith Healer
   a. yes
   b. no

109. Book or other media (_____)
   a. yes
   b. no

110. Other (_____)
   a. yes
   b. no

II. Are there any herbs, medicines, or remedies that it is important to avoid taking when you are pregnant? (Please list and tell me in your own words why each is important).

_____

_____

_____

Where did you get that information?

111. Mother
   a. yes
   b. no

112. Grandmother
    a. yes
    b. no

113. Husband
    a. yes
    b. no

114. Relative (_____)
    a. yes
    b. no

115. Friend
    a. yes
    b. no

116. Doctor
    a. yes
    b. no

117. Nurse
    a. yes
    b. no

118. Faith Healer
    a. yes
    b. no

119. Book or other media (_____)
    a. yes
    b. no

120. Other (_____)
    a. yes
    b. no

121. Do you think that is important to have regular health care during pregnancy?
    a. yes
    b. no

122. At what point in pregnancy should one seek prenatal care?
    a. As soon as possible after finding out one is pregnant
    b. When one feels sick
    c. Late in pregnancy
    d. When it is time to deliver
    e. It isn't necessary to seek prenatal care at all

123. If you feel that prenatal care is important, to whom would you rather go for that care? (Check first choice only).
    a. Private Doctor
    b. Clinic
    c. Lay Practitioner
    d. Certified Nurse-Midwife
    e. Other (_____)

124. Do you have female family members who discuss their own previous pregnancies with you?
    a. yes
    b. no

125. If you do have female family members who discuss their own previous pregnancies with you, have any of them told you of any problems involved with their pregnancies?
    a. yes
    b. no
    c. not applicable

126. Do the other women in your family think that prenatal care is important?
    a. yes
    b. no
    c. some yes, some no

127. Do any of your female family members give you advice about your pregnancy?
    a. yes
    b. no

128. Do you have friends who are pregnant or who have been pregnant since you have known them?
    a. yes
    b. no

129. Do your friends give you advice about pregnancy?
    a. yes
    b. no

130. Do you talk with your friends about pregnancy?
    a. yes
    b. no

131. Do you talk with family members about pregnancy?
    a. yes
    b. no

132. Do you think it is helpful to read books about pregnancy?
    a. yes
    b. no

133. Have you read any books about pregnancy?
    a. yes
    b. no

134. If you were given a booklet about pregnancy, written in Spanish, would you be more likely to read it then if it were written in English?
    a. yes
    b. no

135. Do you think it is helpful to attend classes to teach you about pregnancy, labor and delivery?
    a. yes
    b. no

136. Did you go to childbirth preparation classes when you were pregnant?
    a. yes
    b. no

137. If childbirth preparation classes were offered in Spanish, would you go to them?
    a. yes
    b. no

138. Did your husband or boyfriend talk with you about pregnancy?
    a. yes
    b. no

139. Did your husband or boyfriend try to spend more time with you when you were pregnant?
    a. yes
    b. no

140. If you wanted to go to childbirth classes, would your husband or boyfriend go with you?
    a. yes
    b. no
    c. don't know

141. Does your husband or boyfriend think that you should see a doctor or other health care provider when you are pregnant?
    a. yes
    b. no
    c. don't know

II. Characteristics of the Ideal Service

If a health care service could be developed that you would be able to come to for care during your pregnancy, and that you would feel comfortable coming to what would it be like? Please rate each item according to whether it is very important to you, important, or not important. Please tell the interviewer if there is anything else that is important but that is not on the list.

142. The service should be free.
a. very important b. important c. not important

143. The service should charge small fees according to one's ability to pay.
a. very important b. important c. not important

144. The service should accept Medicaid payments.
a. very important b. important c. not important

145. The service should accept private insurance payment.
a. very important b. important c. not important

146. The service should be located along a bus route.
a. very important b. important c. not important

147. Only health care for pregnant women should be offered.
a. very important b. important c. not important

148. Only health care for all kinds of women's needs should be offered.
a. very important b. important c. not important

149. A full range of health care for the entire family should be offered.
a. very important b. important c. not important

150. Some of the health care providers should speak Spanish.
a. very important b. important c. not important

151. All of the health care providers should speak Spanish.
a. very important b. important c. not important

152. The health care providers should all be men.
a. very important b. important c. not important

153. The health care providers should all be women.
a. very important b. important c. not important

154. The health care providers should be both men and women.
a. very important b. important c. not important

155. The service should offer child care so that I can bring my other children while I am being seen.
a. very important b. important c. not important

156. There should be Spanish-language information booklets available.
a. very important b. important c. not important

157. Childbirth classes in Spanish should be offered at the service.
a. very important b. important c. not important

158. Care should be offered to people whether or not they are U.S. citizens.
a. very important b. important c. not important

159. All information about patients, including their address and legal residence status, should be kept secret.
a. very important b. important c. not important

160. I should not have to wait more than 15 minutes before being seen.
a. very important b. important c. not important

161. The clinic should be a pleasant relaxed place with friendly people.
a. very important b. important c. not important

162. Please check the area of town which would be the most convenient for locating a service which offers health care for pregnant women.
a. East b. West c. Central City d. North e. South

IIA. Other_____.

III. Childbearing Health Locus of Control *

163. Even though it is difficult to arrange, I can have the kind of childbearing experience I want.
a. agree b. disagree

164. I can reduce or eliminate painful sensations during labor by what I do whenever they occur.
a. agree b. disagree

165. Women who are prepared to work actively with the labor and delivery process will have an easier childbirth.
a. agree b. disagree

166. If I commit myselt to active participation during childbirth, I will have a much easier experience.
a. agree b. disagree

167. My personal health practices are the best means of influencing the outcome of pregnancy.
a. agree b. disagree

168. A woman can avoid most complications of pregnancy by what she does to take care of herself.
a. agree b. disagree

169. It is best if I just follow whatever my doctor's or midwife's usual practices are in labor and delivery.
a. agree b. disagree

170. It is best to leave the decisions about maternity care to the professionals.
a. agree b. disagree

171. I basically trust the competence of physicians during pregnancy and would follow their advice without question.
a. agree b. disagree

172. During the childbearing period I should do what my doctor or midwife tells me to regardless of my personal preferences.
a. agree b. disagree

*Reprinted with permission of Foster, J.C. Utah test for the childbearing year. Unpublished doctoral dissertation, The University of Utah, 1981.

173. In order to have a good labor and delivery experience I need to go along with the desires of those in charge of care.
a. agree b. disagree

174. The woman and her partner are mostly submissive to the doctor's wishes during childbearing.
a. agree b. disagree

175. I depend on experts to tell me most of what I need to know about caring for my body.
a. agree b. disagree

176. Just being in the hospital for childbirth would make me feel safe.
a. agree b. disagree

177. It is good luck if I have an easy time during childbearing.
a. agree b. disagree

178. Most of the common discomforts during pregnancy just have to be endured as there really isn't anything much to relieve them.
a. agree b. disagree

179. Some women are just fated to have complications with childbearing.
a. agree b. disagree

180. A baby's growth and development is largely due to factors beyond the parents' control.
a. agree b. disagree

181. I can't do anything to influence the labor and delivery process.
a. agree b. disagree

182. There is nothing I can personally do to reduce pain during birth.
a. agree b. disagree

IV. Social Contacts/Isolation

183. Do you have family or relatives living within 50 miles of your present residence?
   a. yes
   b. no

184. Do you have friends in your neighborhood?
   a. yes
   b. no

185. How often do you see and visit with your relatives?
   a. weekly
   b. monthly
   c. yearly
   d. very seldom
   e. never

186. How often do you see and visit with your friends?
   a. weekly
   b. monthly
   c. yearly
   d. very seldom
   e. never

187. If your family lives far away, are you ever able to talk with them on the telephone?
   a. yes
   b. no

188. How many people live in your present place of residence not including yourself?
   a. 1
   b. 2
   c. 3
   d. 4 or more
   e. none

IVA. How are those people related to you?
   a. Husband or boyfriend_____
   b. Children_____
   c. Parents_____
   d. In-laws_____
   e. Other_____
   f. No relation_____

V. Demographic Data

VA. Age_____

189. Primary language.
   a. English
   b. Spanish
   c. Other (_____)

190. Other languages spoken.
   a. English
   b. Spanish
   c. Other (_____)

191. Language spoken in the home.
   a. English
   b. Spanish
   c. Other (_____)

192. Marital status:
   a. Married
   b. Single
   c. Separated
   d. Divorced
   e. Widowed

VB. Occupation
   a. Subject_____
   b. Spouse_____

193. Are you a U.S. citizen?
   a. yes
   b. no

194. If not a U.S. citizen:
   a. permanent resident
   b. nonresident
   c. not applicable

195. Place of birth:
   a. Utah
   b. Other State (_____)
   c. Mexico
   d. Other Country (_____

196. Length of time in the SALT area at time of delivery.
   a. Less than 6 months
   b. Between 6 months and 1 year
   c. 1 to 2 years
   d. More than 2 years
   e. All of my life

VI. Pregnancy History

197. Are you pregnant now?
   a. yes
   b. no
   c. don't know

VIA. Full term pregnancies_____

VIB. Preterm pregnancies_____

VIC. Miscarriages_____

VID. Abortions_____

VIE. Living children_____

VIF. Live birth babies now living_____

VIG. Live birth babies now dead_____

VIH. Terminations at more than 20 weeks_____

VII. Terminations at less than 20 weeks_____

VIJ. Last normal menstrual period (first day)_____

VIK. Total weight gain during your last pregnancy_____

VIL. Weight of last baby at birth_____

VIM. Length of last pregnancy in months_____

198. Did you feel that there were any problems with your last pregnancy?
   a. yes_____
   b. no

199. If you received health care during your last pregnancy, did your health care provider tell you of any problems with the pregnancy?
   a. yes_____
   b. no
   c. not applicable

200. Do you have any health problems which might affect the outcome of a pregnancy?
   a. yes_____
   b. no

VIN. How many times did you go for care or checkups during your last pregnancy?_____

VIO. At what point in your last pregnancy did you begin receiving care? (In months) _____

201. Do you think you had adequate prenatal care during your last pregnancy?
   a. yes_____
   b. no

What were your reasons for not seeking more health care during your last pregnancy? (Please check all that apply)

202. It is not important.
   a. yes
   b. no

203. I did not feel sick.
   a. yes
   b. no

204. I was afraid that my status as a nonresident might be reported.
   a. yes
   b. no

205. Can't afford more health care.
   a. yes
   b. no

206. Did not have time for appointments.
   a. yes
   b. no

207. Did not have transportation
   a. yes
   b. no

208. I feel uncomfortable having my body examined by a care provider.
   a. yes
   b. no

209. I feel uncomfortable having my body examined by a man.
   a. yes
   b. no

210. Other (_____)

Do you use any method of family planning or birth control?

211. Pill
   a. yes
   b. no

212. IUD
   a. yes
   b. no

213. Foam or jelly to prevent conception
   a. yes
   b. no

214. Condoms
   a. yes
   b. no

215. Diaphragm
   a. yes
   b. no

216. Other (_____)
   a. yes
   b. no

217. None
   a. yes
   b. no

218. Do you plan to have more children?
   a. yes_____
   b. no

VII. Financial Status

219. Average monthly take home income for family from all sources.
   a. less than $200
   b. between $200 and $400
   c. between $400 and $600
   d. more than $600

220. Do you receive welfare?
   a. yes (State type received _____)
   b. no

221. Do you receive Social Security benefits?
   a. yes
   b. no

222. Are you covered by Medicaid?
   a. yes
   b. no

223. Are you currently employed?
   a. yes
   b. no

224. Is your spouse currently employed?
   a. yes
   b. no
   c. not applicable

225. If your spouse is unemployed, is he
   a. looking for a job
   b. in school
   c. disabled
   d. laid off
   e. not applicable

226. Home
   a. own
   b. rent

VIIA. If you had $100 more income monthly, what would you like to see this money spent for? (Number 123456...with #1 being the most important item).
   _____food
   _____clothing
   _____housing
   _____car/transportation
   _____education
   _____health care
   _____recreation
   _____other (_____)

VIII. Information Seeking Practices

*Lee, Isaiah C. Medical Care in a Mexican Community, Los Alamitos, Hwong Publishing Co., 1974.

227. Do you read the newspaper?
   a. always
   b. often
   c. sometimes
   d. never

228. Do you listen to radio news?
   a. always
   b. often
   c. sometimes
   d. never

229. Do you watch TV news
   a. always
   b. often
   c. sometimes
   d. never

230. Do you read books for information?
   a. always
   b. often
   c. sometimes
   d. never

231. Do you belong to any community group?
   a. yes (List:_____)
   b. no

VIIIA. How do you get information that you need about what services are available in your community?

_____

_____

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I. Creencias Sobre el Buscar Atencíon de Salud y Consejos Sobre la Atencíon de Salud

1. ¿ Tiene usted un doctor para toda la familia?
   a. sí (_____)
   b. no

2. ¿ Asiste usted a cualquier clínica o servicio de salud?
   a. sí (specifique y diga cuando fúe la
   b. no última vez que fue)

¿ Usa usted o ha usado cualquier de los servicios de atencíon de salud ofrecidos del Departamento de Salud del Distrito Weber-Morgan durante los cinco años pasados?

3. Cancer Cervical
   a. sí _____
   b. no

4. Conferencia de Salud de Niños
   a. sí
   b. no

5. Planificacíon Familiar
   a. sí
   b. no

6. Alta Presíon de la Sangre
   a. sí
   b. no

7. Imunizaciones (Vacunas)
   a. sí
   b. no

8. Enfermedades Venereas
   a. sí
   b. no

9. WIC
   a. sí
   b. no

10. Referidos de Riesgo Alto
    a. sí
    b. no

11. Desarrollo de Niños
    a. sí
    b. no

12. Tuberculosis
    a. sí
    b. no

13. Madres Jovenes
    a. sí
    b. no

14. ¿ Estuvo alguna persona de su familia enferma durante los seis meses pasados?
    a. sí
    b. no

IA. Por favor, haga una lista de los miembros familiares que han estado enfermos durante los seis meses pasados.

_____

_____

15. ¿ Recibieron atencíon fuera de la casa?
    a. sí
    b. no
    c. nadie estuvo enfermo

IB. ¿ Adónde fueron esas personas/fue esa persona para recibir atencíon de salud?

_____

16. ¿ Cuando es importante buscar la atencíon de salud?
    a. A lo menos una vez al año si uno se siente enfermo o no
    b. Cuando uno no puede hacer su trabajo
    c. Cuando uno se siente enfermo
    d. Otro_____

Cuando usted está enferma o tiene problemas de familia referente a su enfermidad ¿ a quien va primero para consejos o ayuda?

17. Madre
    a. sí
    b. no

18. Abuela
    a. sí
    b. no

19. Pariente (relativo)
    a. sí
    b. no

20. Amigos (as)
    a. sí
    b. no

21. Enfermera
    a. sí
    b. no

22. Doctor
    a. sí
    b. no

23. Curandera
    a. sí
    b. no

24. Otro (_____)

¿ A cuales otras personas va usted para consejos y ayuda?
(Marca todos)

25. Madre
    a. sí
    b. no

26. Abuela
    a. sí
    b. no

27. Pariente (relativo)
    a. sí
    b. no

28. Amigos (as)
    a. sí
    b. no

29. Enfermera
    a. sí
    b. no

30. Doctor
    a. sí
    b. no

31. Curandera
    a. sí
    b. no

32. Otro (_____)

Cuando usted está embarazada o tiene problemas referente al embarazo ¿ a quien va primero para consejos y ayuda?

33. Madre
    a. sí
    b. no

34. Abuela
    a. sí
    b. no

35. Pariente (relativo)
    a. sí
    b. no

36. Amigos (as)
    a. sí
    b. no

37. Enfermera
    a. sí
    b. no

38. Doctor
    a. sí
    b. no

39. Curandera
    a. sí
    b. no

40. Otro (_____)
    a. sí
    b. no

Las preguntas siguientes especifican al embarazo último que tenía usted.

41. ¿ Cómo supo que estaba embarazada?
    a. Faltaba mensualmente mi período
    b. Sentía nauseas
    c. Fui a un miembro de la familia o un pariente (_____)
    d. Fui a un doctor o una clinica(_____)
    e. Otro (_____)

IC. Cuando ya sabía que usted estaba embarazada, ¿ a quien le dijo? (Por favor, de ponga números en el orden que les dijo con el "1" para la primera persona a quien lo dijo).

a. Marido
b. Madre
c. Pariente (relativo)
d. Amigos (as)
e. Otro (_____)

Si usted tiene preguntas sobre el embarazo, ¿ con quien habla? (Marca todos que apliquen)

42. Madre
a. sí
b. no

43. Abuela
a. sí
b. no

44. Marido
a. sí
b. no

45. Pariente (relativo) (_____)
a. sí
b. no

46. Amigos (as)
a. sí
b. no

47. Doctor
a. sí
b. no

48. Enfermera
a. sí
b. no

49. Curandera
a. sí
b. no

50. Otro (_____)
a. sí
b. no

¿ De quien prefiere usted tomar consejos sobre lo que debe o no debe de hacer cuando está embarazada?

51. Madre
    a. sí
    b. no

52. Abuela
    a. sí
    b. no

53. Marido
    a. sí
    b. no

54. Pariente (relativo) (_____)
    a. sí
    b. no

55. Amigos (as)
    a. sí
    b. no

56. Doctor
    a. sí
    b. no

57. Enfermera
    a. sí
    b. no

58. Curandera
    a. sí
    b. no

59. Libro u otra forma de comunicación pública
    a. sí
    b. no

60. Otro (_____)
    a. sí
    b. no

ID. ¿ Hay algunas cosas especiales que una debe de hacer cuando está embarazada? (Por favor, haga una lista y/o describe, y diga en sus propias palabras porque cada cosa en la lista es importante).

_____
_____
_____

¿ De quien recibío esa informacíon?

61. Madre
    a. sí
    b. no

62. Abuela
    a. sí
    b. no

63. Marido
    a. sí
    b. no

64. Pariente (relativo) (_____)
    a. sí
    b. no

65. Amigos (as)
    a. sí
    b. no

66. Doctor
    a. sí
    b. no

67. Enfermera
    a. sí
    b. no

68. Curandera
    a. sí
    b. no

69. Libro u otra forma de comunicacíon pública (_____)
    a. sí
    b. no

70. Otro (_____)
    a. sí
    b. no

IE. ¿ Hay algunas cosas especiales que una no debe de hacer cuando está embarazada? (Por favor, haga una lista y/o describe, y diga en sus propias palabras porque cada cosa en la lista es importante).

_____
_____
_____

¿ Dónde obtuvo esa informacion?

71. Madre
    a. sí
    b. no

72. Abuela
    a. sí
    b. no

73. Marido
    a. sí
    b. no

74. Pariente (relativo) (_____)
    a. sí
    b. no

75. Amigos (as)
    a. sí
    b. no

76. Doctor
    a. sí
    b. no

77. Enfermera
    a. sí
    b. no

78. Curandera
    a. sí
    b. no

79. Libro u otra forma de comunicación pública (_____)
    a. sí
    b. no

80. Otro (_____)
    a. sí
    b. no

IF. ¿ Hay algunas comidas que son importates comer cuando una está embarazada? (Por favor, haga una lista y/o describe, y diga en sus propias palabras porque cada cosa en la lista es importante).

_____
_____
_____

¿ Dónde obtuvo esa informacíon?

81. Madre
    a. sí
    b. no

82. Abuela
    a. sí
    b. no

83. Marido
    a. sí
    b. no

84. Pariente (relativo) (_____)
    a. sí
    b. no

85. Amigos (as)
    a. sí
    b. no

86. Doctor
    a. sí
    b. no

87. Enfermera
    a. sí
    b. no

88. Curandera
    a. sí
    b. no

89. Libro u otra forma de comunicación pública(_____)
    a. sí
    b. no

90. Otro (_____)
    a. sí
    b. no

IG. ¿ Hay algunas comidas que una no debe de comer cuando está embarazada? (Por favor, haga una lista describe, y diga en sus propias palabras porque cada cosa en la lista es importante).

_____

_____

_____

¿ Dónde obtuvo esa informacíon?

91. Madre
    a. sí
    b. no

92. Abuela
    a. sí
    b. no

93. Marido
    a. sí
    b. no

94. Pariente (relativo) (_____)
    a. sí
    b. no

95. Amigos (as)
    a. sí
    b. no

96. Doctor
    a. sí
    b. no

97. Enfermera
    a. sí
    b. no

98. Curandera
    a. sí
    b. no

99. Libro u otra forma de comunicación pública (_____)
    a. sí
    b. no

100. Otro (_____)
    a. sí
    b. no

IH. ¿ Hay yerbas, medecinas o remedios que son importantes tomar cuando una está embarazada? (Por favor, haga una lista y/o describe, y diga en sus propias palabras porque cada cosa en la lista es importante).

_____
_____
_____

¿ Dónde obtuvo esa información?

101. Madre
    a. sí
    b. no

102. Abuela
   a. sí
   b. no

103. Marido
   a. sí
   b. no

104. Pariente (relativo) (_____)
   a. sí
   b. no

105. Amigos (as)
   a. sí
   b. no

106. Doctor
   a. sí
   b. no

107. Enfermera
   a. sí
   b. no

108. Curandera
   a. sí
   b. no

109. Libro u otra forma de comunicación pública (_____)
   a. sí
   b. no

110. Otro (_____)
   a. sí
   b. no

II. ¿ Hay algunas yerbas, medecinas o remedios que una no debe de usar cuando está embarazada? (Por favor, haga una lista y/o describe, y diga en sus propias palabras porque cada cosa en la lista es importante).

_____

_____

_____

¿ Donde obtuvo esa informacion?

111. Madre
   a. sí
   b. no

112. Abuela
     a. sí
     b. no

113. Marido
     a. sí
     b. no

114. Pariente (relativo) (_____)
     a. sí
     b. no

115. Amigos (as)
     a. sí
     b. no

116. Doctor
     a. sí
     b. no

117. Enfermera
     a. sí
     b. no

118. Curandera
     a. sí
     b. no

119. Libro u otra forma de communicación pública(_____)
     a. sí
     b. no

120. Otro (_____
     a. sí
     b. no

121. ¿ Cree usted que es importante tener atencíon regular durante el embarazo?
     a. sí
     b. no

122. ¿ A qúe punto del embarazo debe una mujer buscar atencíon prenatal?
     a. En el momento que sabe que está embarazada
     b. Cuando una se siente enferma
     c. Tarde en el embarazo (la preñez)
     d. Cuando es tiempo parir
     e. No es necesario buscar atencíon prenatal

123. Si usted cree que la atencíon prenatal es importante, ¿ a quien prefiere ir por esa atencíon? (Marca lo más preferido).
   a. Doctor Privado
   b. Clínica
   c. Practicionador laisa (partera)
   d. Partera Certificada
   e. Otro (_____)

124. ¿ Tiene usted miembras de la familia que hablan de sus embarazos pasados con usted?
   a. sí
   b. no

125. Si usted tiene miembras de la familia que hablan de sus embarazos pasados con usted, ¿ le han dicho algunas de ellas de problemas que tenían con sus embarazos?
   a. sí
   b. no
   c. no aplicable

126. ¿ Creen las otras mujeres en su familia que la atencíon prenatal es importante?
   a. sí
   b. no
   c. algunas sí, algunas no

127. ¿ Le dan consejos algunas de las miembras de su familia sobre el embarazo?
   a. sí
   b. no

128. ¿ Tiene usted amigas que están embarazadas o que han estado desde que usted las ha conocido?
   a. sí
   b. no

129. ¿ Le dan consejos sus amigas sobre el embarazo?
   a. sí
   b. no

130. ¿ Habla usted con sus amigas del embarazo?
   a. sí
   b. no

131. ¿ Habla usted con miembras de su familia del embarazo?
   a. sí
   b. no

132. ¿ Cree usted que se ayuda leer libros sobre el embarazo?
     a. sí
     b. no

133. ¿ Ha leido usted algunos libros sobre el embarazo?
     a. sí
     b. no

134. Si le dieran un libro sobre el embarazo, escrito en español, ¿ hay más chance de que lo leyera que si fuera escrito en inglés?
     a. sí
     b. no

135. ¿ Cree usted que se ayuda asistir a clases para enseñarle del embarazo y el alumbramiento?
     a. sí
     b. no

136. ¿ Fue usted a clases de preparacíon para el parto cuando estaba embarazada?
     a. sí
     b. no

137. Si clases de preparacíon para el parto fueron ofrecidas en expalol, ¿ iría usted?
     a. sí
     b. no

138. ¿ Habló usted con su marido o su novio sobre el embarazo?
     a. sí
     b. no

139. ¿ Trataba su marido o novio de pasar más tiempo con usted cuando estaba embarazada?
     a. sí
     b. no

140. ¿ Si usted quisiera asistir a clases de preparacíon para el parto, ¿ iría su marido o novio con usted?
     a. sí
     b. no
     c. no sé

141. ¿ Cree su marido o novio que usted debe de ver a un doctor o a otra persona que provee atencíon de salud cuando usted está embarazada?
     a. sí
     b. no
     c. no sé

II. Caracteristicos del Servicio Ideal

Si se pudiera desarrollar un servicio de salud al cúal usted podría venir, y al cúal usted se sentiría agusto viniendo, ¿ cómo sería? Favor evaluar cada artículo segun si le parece muy importante, importante, o no importante. Favor decir a la investigadora si hay algo más que es importante pero que no está en la lista.

142. El servicio debe de ser gratis.
a. muy importante b. importante c. no importante

143. El servicio debe de cobrar pagos chicos segun la abilidad que tiene uno de pagar.
a. muy importante b. importante c. no importante

144. El servicio debe de aceptar pacios de medicaid.
a. muy importante b. importante c. no importante

145. El servicio debe de aceptar pagos de aseguranza privada.
a. muy importante b. importante c. no importante

146. El servicio debe de ser situado en un ruto de autobús camion.
a. muy importante b. importante c. no importante

147. Nomas atencíon para mujeres embarazadas debe de ser ofrecido.
a. muy importante b. importante c. no importante

148. Nomas atencíon para todas clases de las necesidades de mujeres debe de ser ofrecido.
a. muy importante b. importante c. no importante

149. Todas clases de atencíon de salud para toda la familia deben de ser ofrecido.
a. muy importante b. importante c. no importante

150. Algunas de las personas que proveen atencíon de salud deben de hablar español.
a. muy importante b. importante c. no importante

151. Todas las personas que proveen atencíon de salud deben de hablar español.
a. muy importante b. importante c. no importante

152. Todas las personas que proveen atencíon de salud deben de ser hombres.
a. muy importante b. importante c. no importante

153. Todas las personas que proveen atencíon de salud deben de ser mujeres.
a. muy importante b. importante c. no importante

154. Las personas que proveen atencíon de salud deben de ser ambos hombres y mujeres.
a. muy importante b. importante c. no importante

155. El servicio debe de ofrecer cuidado para los niños para que pueda traer a mis otros niños mientras que me dan atencíon.
a. muy importante b. importante c. no importante

156. Debe de haber obtenible libritos de informacíon escritos en español.
a. muy importante b. importante c. no importante

157. Clases de preparacíon para el parto deben de ser ofrecidos en español en el servicio.
a. muy importante b. importante c. no importante

158. Atencíon de salud debe de ser ofrecido a gente si son ciudadanos de los Estados Unidos o no.
a. muy importante b. importante c. no importante

159. Toda la informacíon de los pacientes, incluso a su direccíon y su estado legal de residencia (si es ciudadano de los Estados Unidos o si tiene papeles o no) debe de ser mantenido secreto.
a. muy importante b. importante c. no importante

160. No deba de esperar más de 15 minutos antes de que me dan atencíon.
a. muy importante b. importante c. no importante

161. La clínica debe de ser un lugar agradable y relajado con gente amicable.
a. muy importante b. importante c. no importante

162. Favor marcar el área de la ciudad que sería más conviniente para situar un servicio que ofrece atencíon de salud para mujeres embarazadas.
   a. Este
   b. Oeste
   c. el Centro
   d. Norte
   e. Sur

IIA. Otro _____.

III. Sentido de Control Sobre la Salud Durante el Embarazo y el Alumbramiento

163. Aunque es difícil para arreglar, yo puedo tener el tipo de parto que quiero.
a. Estoy de acuerdo b. No estoy de acuerdo

164. Yo puedo reducir o eliminar sensaciones de dolor durante el alumbramiento por lo que yo hago cuando ocurrecen.
a. Estoy de acuerdo b. No estoy de acuerdo

165. Mujeres que son preparadas a trabajar activamente con el proceso del alumbramiento tendŕan un parto mas fácil.
a. Estoy de acuerdo b. No estoy de acuerdo

166. Si me comito a participacíon activa durante el parto tendŕe una experiencia mucho más fácil.
a. Estoy de acuerdo b. No estoy de acuerdo

167. Mis practicos personales de salud son los modos mejores de influenciar el resulto del embarazo.
a. Estoy de acuerdo b. No estoy de acuerdo

168. Una mujer puede evitar la mayor parte de las complicaciones del embarazo por lo que hace para cuidarse ella misma.
a. Estoy de acuerdo b. No estoy de acuerdo

169. Es mejor si yo sigo los prácticos usuales de mi doctores o partera durante el alumbramiento y el parto.
a. Estoy de acuerdo b. No estoy de acuerdo

170. Es mejor dejar las decisiones sobre el cuidado de maternidad a los profesionales.
a. Estoy de acuerdo b. No estoy de acuerdo

171. Yo tengo confianza en la competencia de los doctor durante el embarazo y seguiŕia sus consejos sin preguntar.
a. Estoy de acuerdo b. No estoy de acuerdo

172. Durante el tiempo del embarazo y el alumbramiento yo debo de hacer lo que me dice mi doctor o partera sin pensar de mis preferencias personales.
a. Estoy de acuerdo b. No estoy de acuerdo

173. Para tener una experiencia buena del alumbramiento y parto necesito conformar con los deseos de los que tienen autoridad sobre la atencíon que estoy recibiendo.
a. Estoy de acuerdo b. No estoy de acuerdo

174. La mujer y su compañero son principalmente sumiso a los deseos del doctor durante el alumbramiento.
a. Estoy de acuerdo b. No estoy de acuerdo

175. Yo dependo en los expertos para decirme la mayoridad de lo que necesito saber para cuidar mi cuerpo.
a. Estoy de acuerdo b. No estoy de acuerdo

176. No mas estando en el hospital para el parto me haría sentir seguridad.
a. Estoy de acuerdo b. No estoy de acuerdo

177. Es buena suerte si tengo un tiempo fácil durante el parto.
a. Estoy de acuerdo b. No estoy de acuerdo

178. Las dolencias mas frequentes del embarazo solo hay que durarlas porque de veras no hay mucho para aliviarlas.
a. Estoy de acuerdo b. No estoy de acuerdo

179. Algunas mujeres están destinadas a tener complicaciones con el parto.
a. Estoy de acuerdo b. No estoy de acuerdo

180. El crecimiento y la evolucíon de un bebito dependen en gran parte en elementos fuera del control de los padres.
a. Estoy de acuerdo b. No estoy de acuerdo

181. No puedo hacer nada para influenciar el proceso de alumbramiento y el parto.
a. Estoy de acuerdo b. No estoy de acuerdo

182. No hay nada que yo puedo hacer personalmente para reducir el dolor durante el parto.
a. Estoy de acuerdo b. No estoy de acuerdo

IV. Contactos Sociales/Isolacion

183. ¿ Tiene usted familia o parientes viviendo entre 50 millas de la direccíon donde vive ahora?
   a. sí
   b. no

184. ¿ Tiene usted amigos en su barrio?
   a. sí
   b. no

185. ¿ Con qúe frequencia ve y visita usted con sus parientes?
   a. Cada semana
   b. Cada mes
   c. Cada año
   d. Raramente
   e. Nunca

186. ¿ Con qúe frequencia ve y visita usted con sus amigos?
   a. Cada semana
   b. Cada mes
   c. Dada año
   d. Raramente
   e. Nunca

187. Si su familia vive muy lejos, ¿ puede usted hablar con ellos de vez en cuando por teléfono?
   a. sí
   b. no

188. ¿ Cuantas personas viven en su casa ahora no incluso a usted?
   a. 1
   b. 2
   c. 3
   d. 4 o más
   e. Ningunos

IVA. ¿ Qúe relacíon tienen esas personas a usted? (Favor poner el numero de personas en cada grupo).
   a. Marido o novio _____
   b. Hijos _____
   c. Padres _____
   d. Suegros _____
   e. Otro _____
   f. No relacíon _____

V. Data Demográfica

VA. Edad_____

189. Idioma primario.
   a. Inglés
   b. Español
   c. Otro_____

190. Otros idiomas que se habla.
   a. Inglés
   b. Español
   c. Ningún otro
   d. Otro_____

191. Idioma que se habla en la casa.
   a. Inglés
   b. Español
   c. Los dos
   d. Otro_____

192. Estado civil de casado:
   a. Casada
   b. Soltera
   c. Separada
   d. Divorciada
   e. Viuda

VB. Ocupacíon (Trabajo)
   a. Subjeto_____(nota la designacíon
   b. Esposo_____de la clase de trabajo)

193. Es usted ciudadano de los Estados Unidos?
   a. sí
   b. no

194. Si usted no es ciudadano de los Estados Unidos, ¿ es:
   a. Residente permanente
   b. No-residente
   c. No aplicable

195. ¿ Dónde nació usted?
   a. Utah
   b. Otro Estado
   c. México
   d. Otro Pais

196. Tiempo viviendo en el area de ( ) al tiempo del parto.
   a. Menos de 6 meses
   b. Entre 6 meses y un año
   c. De uno para dos años
   d. Más de 2 años
   e. Toda mi vida

VI. Historia de Embarazos

197. Está usted embarazada ahora?
   a. sí
   b. no
   c. no sé

VIA. Número de embarazos que duraron los 9 meses completos_____

VIB. Número de embarazos que duraron entre 5 y 8 meses_____

VIC. Número de embarazos que duraron 5 meses o menos _____

VID. Número de abortos_____

VIE. Niños vivos ahora_____

VIF. Bebitos vivos todavía_____

VIG. Bebitos que nacieron vivos pero ya muertos_____

VIH. Terminaciones de embarazos a más de 20 semanas_____

VII. Terminaciones de embarazos a menos de 20 semanas _____

VIJ. Último período mensual regla normal (Primer día) _____

VIK. Peso total ganado en su último embarazo_____

VIL. Peso de su último bebito cuando nacío_____

VIM. Duracíon del último embarazo en meses_____

198. ¿ Sentía usted que fúeron algunos problemas con su último embarazo?
   a. sí_____
   b. no

199. Si usted recebio atencíon de salud durante su último embarazo, ¿ le dijo la persona que le estaba cuidando algo de problemas con el embarazo?
   a. sí_____
   b. no

200. ¿ Tiene usted algunos problemas de salud que podrían afectar el resultado de un embarazo?
   a. sí_____
   b. no

VIN. ¿ Cuantas veces fue usted para atencíon o examinaciones durante el ultimo embarazo?_____

VIO. ¿ A qúe punto en su último embarazo (en meses) comenzó usted a recebir atencíon?_____

201. ¿ Cree usted que recibió bastante antencíon prenatal durante su último embarazo?
   a. sí
   b. no

¿ Qué eran sus razones por no buscar más atencion de salud durante su último embarazo?

202. No es importante.
   a. sí
   b. no

203. No me sentía enferma.
   a. sí
   b. no

204. Tenía miedo de que mi estado de ajeno residente sería reporatdo.
   a. sí
   b. no

205. No tenía dinero para mas atencíon de salud.
   a. sí
   b. no

206. No tenía tiempo para las citas.
   a. sí
   b. no

207. No tenía transportacíon.
   a. sí
   b. no

208. Me sentí incómoda tener examinaciones de mi cuerpo por la persona que provee atencíon de salud.
   a. sí
   b. no

209. Me sentí incómoda tener examinaciones de mi cuerpo por un hombre.
   a. sí
   b. no

210. Otro (_____)

¿ Usa usted algun método né planificacion y control familiar?

211. Píldoras pastilla
   a. sí
   b. no

212. IUD
   a. sí
   b. no

213. Espuma o jalea anticonceptivas
   a. sí
   b. no

214. Condones
   a. sí
   b. no

215. Diaframa
   a. sí
   b. no

216. Otro (_____)
   a. sí
   b. no

217. Nada
   a. sí
   b. no

218. ¿ Quiere usted tener mas niños?
   a. sí
   b. no

VII. Estado Financiero

219. ¿ Cúanto dinero gana su familia que pueden usar en un mes típico?
   a. menos de $200
   b. entre $200 y $400
   c. entre $400 y $600
   d. Más de $600

220. ¿ Recibe usted o su familia ayuda del estado?
   a. sí (Diga clase recibido_____)
   b. no

221. ¿ Recibe usted beneficios de Seguro Social?
   a. sí
   b. no

222. ¿ Recibe usted ayuda de Medicaid?
   a. sí
   b. no

223. ¿ Está usted empleada ahora? (¿ Tiene usted trabajo ahora?)
   a. sí
   b. no

224. ¿ Está su esposo empleado ahora? (¿ Tiene su esposo trabajo ahora?)
   a. sí
   b. no

225. Si su esposo no tiene trabajo, ¿ está:
   a. Buscando trabajo
   b. En la escuela
   c. Enfermo o herido de algun modo que no puede trabajar
   d. Sin trabajo porque el lugar dónde estaba trabajando dejo ir varios de sus empleados porque no habia bastante trabajo
   e. No aplicable

226. Casa
   a. Comprando o ya es mia o de mi familia
   b. Rentando

VIIA. Si usted tenía ostros $100 cada mes, ¿ para qúe preferia gastar ese dinero? (Favor marcar todos los que apliquen, poniendo números para evaluar las cosas que marca, con el #1 para lo mas importante).

_____comida
_____ropas
_____casa
_____carro/transportacion
_____educacion
_____cuidado de salud
_____divertimientos
_____otro (_____)

VIII. Practicos de Buscar Información

227. ¿ Lee usted el períodico?
   a. Siempre
   b. Muchas veces
   c. A veces
   d. Nunca

228. ¿ Escucha usted las noticias de radio?
   a. Siempre
   b. Muchas veces
   c. A veces
   d. Nunca

129. ¿ Mira usted las noticias de televisíon?
   a. Siempre
   b. Muchas veces
   c. A veces
   d. Nunca

230. ¿ Lee usted libros por informacíon?
   a. Siempre
   b. Muchas veces
   c. A veces
   d. Nunca

231. ¿ Corresponde usted a cualquier grupo de la comunidad?
   a. sí (Favor hacer una lista:_____)
   b. no

VIIIA. ¿ Cómo obtiene usted informacíon que necesita sobre los servicios que son obtenibles en su comunidad?

_____

_____

APPENDIX B

AVAILABILITY OF PRENATAL CARE IN THE WEBER-MORGAN DISTRICT AT THE TIME OF THIS STUDY

Seventeen specialists in Obstetrics/Gynecology, all of whom were Caucasian males, were located in Ogden's east bench area. One group of private Family Practice physicians and the FHP (Family Health Plan) Clinic were also located in that area.

Near the downtown area on one of the main streets there was a Community Health Center. One of the Family Practice physicians employed at the Ogden Community Health Center was fluent in Spanish. Two hospitals were available to provide delivery services.

No services were available on a sliding-scale fee basis. No female Obstetric specialist or Family Practice physicians were available. Certified Nurse-Midwives were not providing care in the Ogden area.*

* Information from Gail C. Evans RN, MSN, CNM, Maternal Health Consultant for the Utah Department of Health in private conversation.

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